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# CITY OF BOSTON

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# Man Who Made Boston Survey

(Photo by Keller)

**ROBERT P. LANE**

NEW YORK, Feb. 10—Robert P. Lane, who directed the Greater Boston Community survey, is one of the half-dozen best-known social workers in the United States, due principally to his 12-year tenure of the position of Executive Director of the Welfare Council of New York City.

New York was one of the last big cities in the United States to form a welfare council to co-ordinate the activities of its various charitable organizations and, because of the city's size, its social services were in a chaotic state when Lane took over. The Welfare Council has more than 750 member organizations, three times as big as the nation's next largest council, in Chicago.

* * *

Mr. Lane was appointed to his post July 1, 1934, in the progressive regime of the late Fiorello H. La Guardia, former Mayor. He resigned in April, 1946.

In that period, Mr. Lane gave pattern to the huge and sprawling conglomeration over which he presided. To illustrate: He had to know of a research project for an extremely rare disease at one hospital—a disease a charitable agency might not meet once in 50 years—and of a program for diabetic treatment at another hospital. He had to be sure that the small Borough of Staten Island—population 180,000—had proportionately as much social service at Brooklyn—population 2,800,000. He had to be sure that Negro medical service as Polish families in Queens; he recruited volunteer playground workers; visited homes for backward children; looked in on sanitariums for the tubercular. He attacked the problem of juvenile delinquency and venereal disease and a thousand others. He argued for and against legislation and made speeches, speeches, speeches.

* * *

Mr. Lane was born in Fort Wayne, Ind., April 7, 1891. While he was a student at the University of Michigan, he heard that the Governor, Chase S. Osborn, needed a secretary. He learned stenography in two weeks and got the job. He held the job a year, also serving as secretary to the Michigan State Board of Pardons, then returned to the university to take his degree.

After graduation, Mr. Lane served as an instructor at the university, spending two years each in the departments of rhetoric and political science. He then joined the business department of the Curtis Publishing Company. The American Red Cross borrowed him in 1919, and he stayed with the Red Cross until 1923, ending as European director in Paris. He lectured for the Carnegie Endowment for International Peace, returned to the Red Cross for two years, then went back to Curtis.

In 1929 he went to Dartmouth College as associate professor of industrial society, a position he held until 1933. Then the Federal Government borrowed him to serve on the newly-created Central Statistical Board, a post he held until he went to New York. He is married

# GREATER BOSTON COMMUNITY SURVEY

*conducted by the*

## COMMITTEE OF CITIZENS

*To Survey the Social and Health Needs and Services*

*of Greater Boston*

## 1947 - 1949

*February, 1949*

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NOTE: A basic "Time Analysis Study" has not been summarized in this Report, but is filed with the Greater Boston Community Council (Research Bureau)

Many recommendations in this Summary Report and the Divisional Reports place great reliance on a strong central planning body. For discussion and recommendations on this subject, see pp. 135-142.

# GREATER BOSTON COMMUNITY SURVEY

CONDUCTED BY THE

## COMMITTEE OF CITIZENS

TO SURVEY THE SOCIAL AND HEALTH NEEDS AND SERVICES OF GREATER BOSTON

261 FRANKLIN STREET, BOSTON 10, MASSACHUSETTS

HUBBARD 2-8600

ROBERT P. LANE
DIRECTOR OF THE SURVEY

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HAROLD D. ULRICH
JOSEPH T. WALKER, JR.
DOROTHY W. MYERS
SECRETARY OF THE COMMITTEE


February 8, 1949

To: Members of the Committee of Citizens:

We have the honor to transmit to the Committee of Citizens a Summary Report of the Greater Boston Community Survey. We unanimously recommend that you adopt this Report and publish it to the people of Greater Boston.

The Summary Report, drafted by Mr. Robert P. Lane, Director of the Survey, is based upon six Divisional Reports prepared by the professional staff:

(1) Health Division Report (206 pages)
(2) Hospital Division Report (160 pages)
(3) Public Welfare Division Report (55 pages)
(4) Voluntary Casework Division Report (231 pages)
(5) Group Work and Recreation Division Report (163 pages)
(6) Planning and Financing Division Report (44 pages)

These Divisional Reports, together with a great mass of supporting data, have been filed for convenience with the Greater Boston Community Council. We unanimously approve these Divisional Reports, with the exceptions noted therein.

The Summary Report, the Divisional Reports, and the supporting data have been prepared in accordance with the "Statement of Policies" which has guided us from the outset (Annex A, page vi). A cardinal policy was to respect the integrity of the Reports submitted by the professional staff.

The principal agencies in the area covered by the Survey are listed in Annex B (page viii). The professional staff responsible, under the Director, for each Divisional Report is listed in Annex C (page xiv).

In conformity with the "Statement of Policies", the Divisional Reports in tentative form were sent to agencies affected thereby, which were invited to submit written comments. The Executive Committee received written comments from many agencies and also held many conferences with agencies requesting such meetings.

To the extent that the professional staff and the undersigned agreed with such written and oral comments, they have been incorporated in the final form of the Divisional Reports and in the Summary Report. The written comments are appended to the original copies of the Divisional Reports to which they refer. To the extent not so incorporated in the Divisional Reports, such appended comments are not agreed to by the undersigned; and notation regarding them appears in the Summary Report. As stated above, we strongly support the final Divisional Reports as filed and circulated to affected agencies.

To aid in understanding our work, we have prepared and attach a "Brief Historical Account" of the Survey (pages iii to v).

We wish to acknowledge our debt to the Survey professional staff. They have performed, with faith and integrity, a service to the people of Greater Boston. The members of the Executive Committee established an intimate, fortunate, and fruitful relation with the Director, Mr. Lane. A better directing head for this task could not have been found. During our two years of association, we have constantly found in him fresh proofs of ability, flexibility, common sense, and command of the subject.

There are more than 800 voluntary and tax-supported social and health agencies in the 55 independent communities comprising the Greater Boston area. Throughout our long work, the members of the Executive Committee have been animated by an objective spirit, seeking only what is best for the most people in our community. We ask that all people of good-will receive and act upon the Survey recommendations in a like spirit of impartiality and unselfish thought for the common good.

We do not take the position that the program of the Summary Report is the only solution to Greater Boston's problem, or that it must be followed without any deviation. But we do say this: unless some such comprehensive, integrated program as that we recommend is undertaken, and undertaken soon, there is danger that the whole structure of unified charitable action in Greater Boston will fall apart. We believe deeply in the efficacy of that structure. We think it has preserved our charitable organizations in effective operation, long after many of them would have gone under on the basis of individual action. Even more significant, it has brought closer together in better understanding and neighborliness many and varied groups of people living in our 55 cities and towns. To lose the advantage so gained would be to forfeit much that makes democracy worth while.

We recommend the adoption of the Summary Report, and the supporting Divisional Reports, believing that thereby a great advance will be made towards the high goal of the Survey: to make sure that the charitable dollar annually raised in Greater Boston does the greatest good for the greatest number in the most economical, effective way.

Sincerely yours,

Robert Cutler, Chairman
Arthur G. Rotch, Vice-Chairman
Wilman E. Adams
Mrs. Randolph K. Byers
Powell M. Cabot
Charles C. Dasey
Rev. James H. Doyle
Francis C. Gray
Milton Kahn
Jacob J. Kaplan
M. T. Kelleher
John E. Lawrence
William H. Pear
Mrs. J. H. Perkins
Harold D. Ulrich
Joseph T. Walker, Jr.
Executive Committee

# Brief Historical Account of Greater Boston Community Survey

1. After mature consideration during 1946, special committees of the Greater Boston Community Fund (Messrs. Brace, Rotch, and Walker) and the Greater Boston Community Council (Miss Nelson, Mr. Nichols, Mr. Vorenberg) filed a joint report recommending that an independent group of citizens of Greater Boston should conduct a survey of the area's social and health needs and services. This report was accepted by both the Fund and Council late in 1946.

2. Early in 1947, upon the request of the President of the Fund (Mr. Adams), the President of the Council (Mr. Vorenberg), and the Chairman of the Central Budget Committee (Mr. Rotch), Robert Cutler agreed to serve as Chairman of a citizen group to carry on the recommended survey. Invitations were extended to one hundred and eighty-four representative citizens residing in the Greater Boston area to form themselves into a Committee of Citizens. One hundred and eighty citizens accepted these invitations. On March 7, 1947, they met formally to constitute the Committee of Citizens, and at such meeting published a guiding Outline of Policy (included in "Statement of Policies adopted by Executive Committee," Annex A, page vi).

3. The Committee of Citizens stated the basic objective of the Survey thus: to make sure that the charitable dollar annually raised in Greater Boston does the greatest good for the greatest number in the most economical, effective way. All else was to be subservient to this great goal. Were the community's voluntary agencies providing the most purposeful and thorough-going service to human needs, at levels above that which is basic and should be covered by tax-raised funds? It was obvious that the Survey could most effectively attack the problems and relations of the voluntary agencies, but their relationship with the public agencies in various fields would necessitate a study of the latter as well. Above all, the Committee of Citizens determined to bring forth specific, clear, and dynamic recommendations, capable of being translated into positive action for the benefit of the community, and to marshal public opinion in support of such recommendations.

4. Many reasons exist for making such a survey:

a. Since its establishment in 1935, the Greater Boston Community Fund has grown from a central money-raising body for 115 voluntary agencies in municipal Boston to a federation of 339 voluntary agencies (1948) located in and serving the 55 contiguous but independent cities and towns comprising Greater Boston. After so great and rapid a growth, it is only prudent common sense to have a self-appraisal and to determine afresh how available resources can be used to the maximum advantage. Recurring self-examination is good business and good sense; evidencing that the community is alive to its responsibilities to its citizens.

b. When the public is called upon annually to support the voluntary agencies in a community, it is just, reasonable, and in the best community interest to apply a strong and penetrating judgment to planning the continuance, expansion, consolidation, or elimination of such agencies. The people who give are entitled to know that they are getting the maximum value out of their contributions.

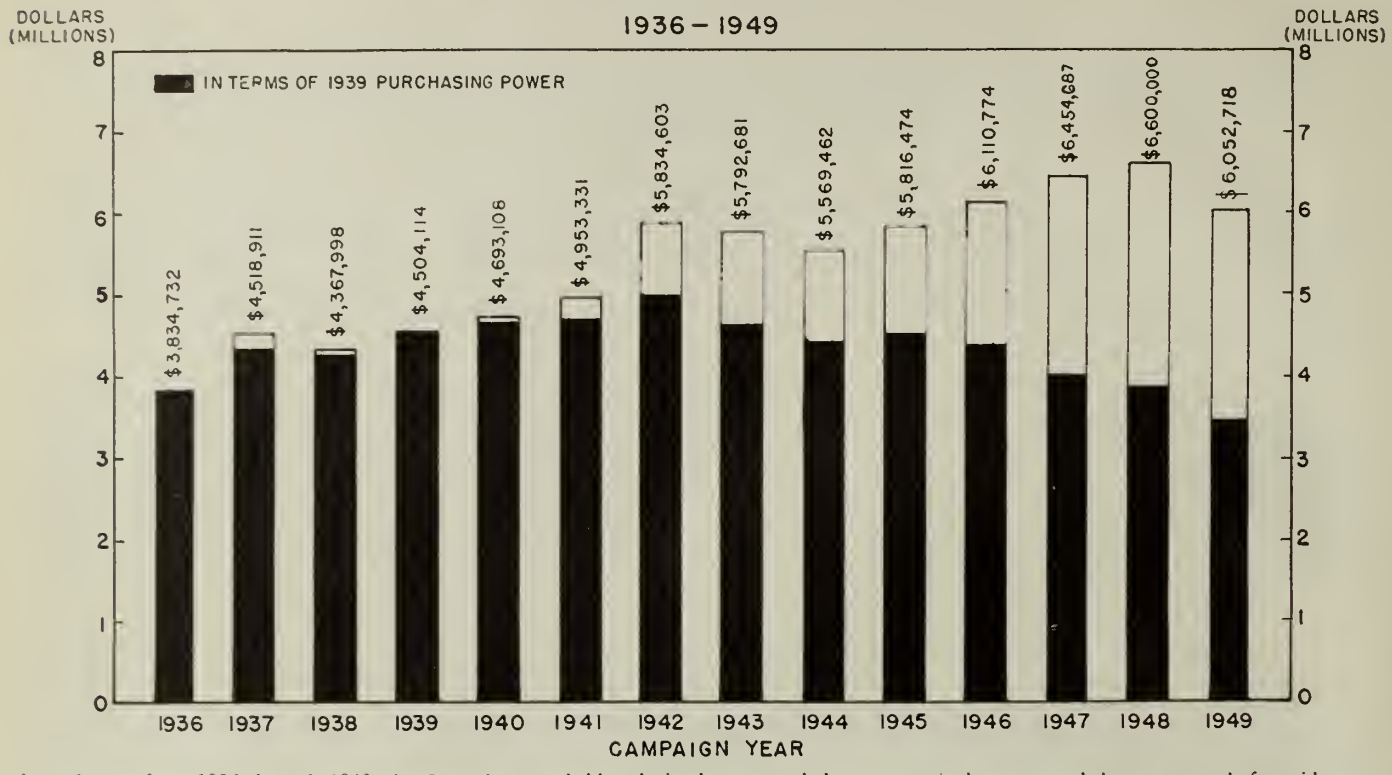
c. Since the Fund's first Campaign in 1936, there has been raised in its fourteen Campaigns an aggregate of $75,097,000 (omitting payments to USO and other war connected agencies). This sum is $14,715,000 less than the aggregate of local agency requests during these years to the Central Budget Committee ($89,812,000). Operating costs have been skyrocketing and agency deficits increasing. Unrestricted endowments are being more and more deeply invaded. Building and repair jobs, long deferred during war, are becoming mandatory. The trend evident in 1946 is growing worse:

| | Aggregate Raised in Campaign for Local Agencies | Aggregate Local Agency Requests to Central Budget Committee | Deficiency |
|---|---|---|---|
| 1946 | $6,110,000 | $7,803,000 | $1,693,000 |
| 1947 | 6,454,000 | 8,659,000 | 2,205,000 |
| 1948 | 6,600,000 | 8,431,000 | 1,831,000 |
| 1949 | 6,053,000 | 8,400,000 (est.) | 2,347,000 (est.) |

d. Charitable agencies are feeling acutely the effect of the rapid rise in the cost of living. The Consumers' Price Index of the U. S. Department of Labor rose from 100 in 1939 to 175 in October, 1948. What a charitable agency could buy for one dollar in 1939 cost in 1948 one dollar and seventy-five cents. The following columnar bar chart graphically contrasts the total dollars raised in each Fund Campaign with what those dollars could buy in terms of 1939 purchasing power. Although the aggregate dollar allotments to 87 agencies (which were continuously in the Fund from 1941 to 1948) were 23% greater in 1948 than in 1941, the purchasing power of these larger 1948 dollar allotments was actually 24% less than the purchasing power of the smaller allotments received in 1941.

e. There is a growing concern over the multiplicity of fund-raising campaigns which flood all months of the calendar other than those in which the Fund Campaigns are held. People generally wish for a positive reassurance of the validity of the Fund appeal; an impartial judgment that the Fund agencies represent the hard core of the community's charitable economy; an expert confirmation that those agencies have a prior call upon the community's generosity.

f. Like other communities, Greater Boston is facing both the dislocations that follow in the wake of War and also the murky future of a world not yet at peace.




In each year from 1936 through 1943, the Campaign was held early in the year and the money raised was expended to meet needs for said year. Late in 1943, the Campaign date was changed. In October-November, 1943, a Campaign (called the "1944 Campaign") was held to raise money to meet needs for the year 1944. In October-November of each year after 1943, a Campaign was held to meet needs for the following year. The columnar bars for the years 1944-1945-1946-1947-1948-1949 represent money raised in October-November of the respective preceding years, but expended to meet needs for the years stated above. . . . The whole columnar bar represents the total dollars raised for local needs (excluding war-connected agencies) by the Campaign. The black portion of the columnar bar represents the purchasing power of the dollars so raised in terms of the 1939 average cost of living (Consumers' Price Index, U. S. Dept. of Labor); except that, for the year 1949, the 1939 average cost of living is related to the Index at October 15, 1948.

5. It was recognized from the start that the Survey was the most complex and far-reaching undertaking of its kind yet to be attempted in the United States. The geographical aspects of the Greater Boston area, which embraces 55 different, self-governing communities of ancient origin, the historical and individualistic backgrounds of these communities, the antiquity and long service of many of the voluntary agencies, and the fact that some 500 voluntary agencies and some 300 public agencies would be involved, provided challenging factors. To meet this challenge, the Executive Committee concluded that there should be assembled the most expert staff which could be obtained in our country. In view of the magnitude of the annual expenditure of public and private funds in the Greater Boston area for the commonly recognized health and welfare services (which totalled in 1946 over $89,000,000), and the justifiable expectations that the findings and specific recommendations of the Survey should continue to benefit the community through many future years, it was felt that a total expenditure by the Survey of between $150,000 and $200,000 would be within reason.

6. At its organization meeting in March, 1947, the Committee of Citizens named an Executive Committee to direct the actual conduct of the Survey:

Robert Cutler, *Chairman*
Arthur G. Rotch, *Vice Chairman*
Wilman E. Adams
Mrs. Randolph K. Byers
Powell M. Cabot
Charles C. Dasey
Rev. James H. Doyle
Francis C. Gray
Milton Kahn
Jacob J. Kaplan
Michael T. Kelleher
John E. Lawrence
William H. Pear
Mrs. J. H. Perkins
Harold D. Ulrich, who succeeded Ernest Johnson on his resignation early in 1948
Joseph T. Walker, Jr.

The first duty of the Executive Committee was to select a Director. After canvassing the national field, the Executive Committee in April, 1947, unanimously selected Robert P. Lane of New York City for this exacting task and placed upon him the responsibility of assembling an expert professional staff.

7. Mr. Lane's acceptance of the post of Survey Director was necessarily conditioned upon his completion of two surveys, on which he was currently engaged, of the cities of Springfield, Mass., and New London, Conn., and upon his having a short vacation. Having outlined for the Committee of Citizens in June, 1947, a "Program for the

Survey," Mr. Lane devoted himself to the task of engaging specialists of outstanding reputation to conduct studies in the several divisional fields: Hospitals; Health; Voluntary Casework; Group Work and Recreation; Public Welfare; Statistical Research; Planning and Financing. It became obvious that in order to obtain leaders in each field, whose judgment would command respect, it would be necessary to accommodate the demands of the Survey to the responsibilities of such men and women. Experts of the required caliber could be engaged only upon the understanding that they might fit the Survey into their manifold existing responsibilities as opportunity should best afford. Accordingly, it developed by the time Mr. Lane had concluded his undertakings at Springfield and New London that there must ensue a much longer period than was at first anticipated to conclude the Survey. Yet the Executive Committee was convinced that the great objective could be best accomplished by engaging experts of the highest quality to do the work, despite some resultant time-lag, than by resorting to personnel of less high caliber who might be immediately available.

8. The Executive Committee maintained constant and close touch with the progress of the Survey. Formal meetings of the Executive Committee (each consuming from 2-6 hours) have been held as follows: *1947* — March 17, March 28, April 1, April 17, May 6, June 10, September 17, October 21, November 6, November 23; *1948* — January 8, February 17, March 22, May 4, June 1, July 8, August 9, August 24, September 15, October 8, October 16, November 1, November 9, November 20, November 23, December 8, December 21, December 27; *1949* — January 17, January 24, February 3 and 5. In addition, many meetings have been held by individual members of the Executive Committee and groups of such members with the Director and his associated specialists in the several fields.

9. The Committee of Citizens met as a whole on March 7 and June 19, 1947 and January 6, 1949. In January, June, September, and December, 1948, extensive progress reports were made by the Executive Committee to the Whole Committee.

10. Various charitable organizations (Greater Boston Community Fund; Godfrey M. Hyams Trust; Permanent Charity Fund, Inc; Theodore Edson Parker Fund; Henry Clay Jackson Fund; Mason Fund Committee) have made grants to defray the cost of the Survey; about five-sixths of which will be covered by the Community Fund's grant. While final figures are not yet available, such cost from March 7, 1947, through January 31, 1949, totalled $178,987. Under the accounting procedure adopted at the outset, all vouchers for Survey expenses have been submitted on a standard form to Mr. Lane as Director for his approval and have then been personally reviewed and initialled by the Chairman (in his absence by the Vice Chairman); and every voucher has been audited by the Comptroller of the Greater Boston Community Fund. Each month the Comptroller has submitted to the Chairman a statement of expenditures in detail, also broken down by Divisions of the Survey, which has been presented to and considered by the Executive Committee at its regular meetings. A tight and workable financial control was instituted and carried on from the beginning.

11. From time to time during the latter part of 1948, the professional staff of the several Survey Divisions concluded their field work and submitted proposed Reports. A copy of each proposed Divisional Report was sent to each member of the Executive Committee for study. After a suitable interval for consideration, the Executive Committee met with the professional staff of the Division concerned one or more times for review, examination, and revision of proposed Report. Thereafter, the revised Divisional Report as tentatively accepted or dissented from by the Executive Committee, was circulated in several copies to the voluntary agencies which might be affected by its proposed findings and recommendations. Each Report so circulated was plainly stamped: "THIS IS A TENTATIVE DRAFT, SUBJECT TO CORRECTION AND REVISION. IT IS CIRCULATED ONLY FOR DISCUSSION PURPOSES TO THOSE FOR WHOM INTENDED AND SHOULD NOT BE QUOTED OR SUMMARIZED." Thus, at a given time in December or January, there were several thousand copies of the tentative Divisional Reports (such Reports aggregating over a thousand pages) in circulation to agencies. These tentative Reports, being subject to almost daily revision, were not furnished to the Whole Committee. It was thought more helpful to await agreement by the Executive Committee on final texts.

12. The Committee's policy provided (Annex A, pages vi-vii): "The fullest cooperation and participation on the part of representatives of the agencies are desired. . . . Voluntary agencies will be invited to submit comments, in succinct written form, on any draft report affecting them. Nothing shall be published prior to such opportunity being offered." In conformity with this policy, the Executive Committee invited affected voluntary agencies to submit, if they wished, written comments upon those tentative Reports which affected them; endeavoring to allow an interval of about three weeks for agency study of such tentative Reports. During December and January a total of 126 agencies submitted written comments to the Executive Committee. Furthermore, sub-committees of the Executive Committee during these months held conferences with representatives of 49 agencies at the latter's request. The professional staff and the Executive Committee derived great benefit from such comments and conferences, in correction of tentative texts and in clearer understanding of agency points of view. While such practice is said to depart from usual community survey procedure and imposes a heavy burden, the Executive Committee deemed it a necessary part of a Survey conducted in accordance with democratic principles.

13. After consideration of the material furnished by the agencies in their written comments and at their oral conferences, the Executive Committee completed further revisions of each Divisional Report before giving final approval. Thereafter, it considered all the Divisional Reports viewed in their interrelation and as a composite whole. Finally, the Executive Committee worked, page-by-page, with the Survey Director in his drafting of the Summary Report, which sets forth the findings and recommendations submitted by the Executive Committee to the Whole Committee for adoption and publication as the SURVEY REPORT.

# ANNEX A

# Statement of Policies Adopted by Executive Committee

## I. PURPOSE AND SCOPE OF THE SURVEY

1. The object of the Survey is to make sure that the charitable dollar annually raised in Greater Boston does the greatest good for the greatest number in the most economical, effective way.

2. The Survey will embrace —

a. studies of the social and health needs of the Greater Boston area;

b. studies of the resources of the Greater Boston area available to meet such needs;

c. studies of the private and public services which minister to such needs, and their relationships; including private agencies which are members of the Fund or Council and those which are not;

d. studies, concurrently carried on, in the several fields of human need (health and care of the sick, family and child care, youth services, recreation, community organization, etc.);

e. studies in detail of the administration and service programs of the individual private agencies as the necessity therefor is indicated in the course of study of the fields;

f. study of the organization and relationship of the Council and the Fund.

3. The Survey will consider the following major problems in the Fund-Council field — such consideration not involving intensive study of Campaign techniques or of Public Relations —

a. relation between the Greater Boston Community Fund and the Greater Boston Community Council;

b. relation between the Greater Boston Community Fund and the Metropolitan Funds;

c. relation between the Greater Boston Community Council and the Metropolitan Councils.

4. The Survey will consider the following points —

a. the critical financial condition of the agencies resulting from operating deficits in excess of Fund allotments;

b. the chartered functions of particular agencies, as distinguished from supplementary functions which they may have gathered through the years;

c. whether it may be more prudent and economical, where an agency originally amply endowed by generous individuals now requires public support through the Fund, to transfer its remaining funds and duties to some other agency; proceeding if need be through the Probate Court or Legislature to lift or modify restrictions.

5. The Survey will consider the question of whether a Citizens' Committee should be established in Greater Boston to advise the general public with reference to the need of various fund-raising campaigns, of which there now is such a multiplicity throughout the year.

6. The Survey will consider the amount annually expended by the Greater Boston Community Fund for service, budgeting, education, planning, and similar objects.

7. In its Report the Survey will cite as a problem for future study, in the interest of better community planning, the need for greater coordination than now exists between private charitable foundations in Greater Boston, the Greater Boston Community Fund, the Greater Boston Community Council, and public agencies in Greater Boston,

8. The Survey will fully co-operate with the Associated Jewish Philanthropies in its detailed, qualitative study of the health work of that organization's health agencies, each group keeping fully informed of the other's progress.

9. The Survey will offer full co-operation to the Finance Commission of the City of Boston in its Study, undertaken in accordance with Legislative Act, of various departments of the City of Boston included within the scope of the Survey.

## II. REPORT OF THE SURVEY

1. The Survey Report in its final form is the report of the Committee of Citizens, and the Committee of Citizens' decision in every respect shall control.

2. The Survey Report will be submitted by the Executive Committee to the Committee of Citizens as a single, integrated, comprehensive entity, and no topic or group of topics will be separately reported upon in advance.

3. The decision of the Executive Committee with respect to the report of any Division of the Survey, and with respect to the Director's Summary Report, will be taken by a majority of the whole number of the Executive Committee at a duly called meeting to consider such Report. Individual members of the Executive Committee may be recorded in the affirmative or negative or not voting, with respect to any Divisional Report (or part thereof) and with respect to the Director's Summary Report (or part thereof).

4. The recommendations of the Survey will be impartial and incisive. They will avoid generalities and technical verbiage; and will be expressed in the Survey Report in straight-forward language understandable by lay citizens. The Survey Report will be so worded that it can be translated into positive action for the benefit of the community.

5. The Survey Report will contain — where needed — specific recommendations for improvement, strengthening, enlargement, consolidation, curtailment, or elimination in regard to fields of service, relationships, and individual agencies. The Survey Report should recommend such adjustments as may be necessary so that the money that can be raised in the community will come nearer to balancing the budgets of the essential community services.

6. The fullest co-operation and participation on the part of representatives of the agencies are desired and will be assured; and they will be afforded opportunity to study, comment upon, and make suggestions as to tentative recommendations before submission of the Survey Report in final form by the Executive Committee to the Committee of Citizens.

## III. PROCEDURE FOR PREPARING SURVEY REPORT

*(NOTE: The Survey operates through the following Staff Divisions: Hospitals; Health; Voluntary Casework; Group Work and Recreation; Planning and Financing; Public Welfare; Statistics and Research; Administrative.)*

1. Because no final action will have been taken prior to step 13 below, there will be no publicity with respect to any of the following steps until just prior to that step.

2. During the completion of their field work, Staff members of a Division of the Survey are free to discuss the formulation of *general principles* applicable to the field covered by such Division with the representatives (professional and lay) of the agencies in such field in any way they deem desirable. In the course of such, and subsequent, procedure, it is desired that contact be developed with lay members of the affected agencies.

3. As a general rule, Staff members of a Division of the Survey will draft from time to time statements of the *general principles* applicable to the field covered by such Division (or to any portion of such field) and will submit such draft statements to the Executive Committee for its approval. A *general principle* which has not been approved by the Executive Committee, or as to which the Executive Committee has not waived submission and approval, will not be binding upon the Executive Committee.

4. A *general principle* approved, or submission of which has been waived, by the Executive Committee may be discussed by Staff members of a Division of the Survey with the representatives (professional or lay) of the agencies in such Division's field in whatever way fits in best with the procedure being followed by such Division.

5. Staff members of a Division of the Survey may proceed as they deem most desirable in formulating *specific recommendations*, including the holding of meetings of affected agencies in such Division's field to consider and discuss such formulation. However, a *specific recommendation* will not be taken up with affected agencies as approved by the Executive Committee until it has been submitted to and approved by the Executive Committee.

6. Such meeting or meetings as may be necessary will be held between the Executive Committee (or a sub-committee) and each Chief (and such aides as he may determine) of the following Divisions — Hospitals; Health; Group Work and Recreation; Voluntary Casework; Public Welfare; Planning and Financing — with respect to each such Division's draft report, including its proposed *specific recommendations*. From the submission of such draft report there may result: (a) acceptance of the draft report by the Executive Committee; (b) mutual agreement to a modified draft report; (c) dissent by the Executive Committee, as a committee, in whole or in part from the draft report.

7. If the Executive Committee is not prepared to accept a recommendation of the Survey Staff as originally submitted, reasonable effort shall be made to compose the difference between the Executive Committee and the Survey Staff to the end that each recommendation shall be acceptable to the Executive Committee. The integrity of the Survey Staff's final conclusions is, however, recognized as a matter of primary importance. In the event of ultimate inability to compose any such difference, the final recommendation of the Staff shall stand. In such event, the Executive Committee, as a Committee, shall prepare a tentative draft of its dissent in writing, succinctly stating reasons.

8. Thereafter, the Executive Committee will circulate the Divisional draft report, as received or as modified, to affected agencies, indicating that the Executive Committee has not taken final action thereon; except in the case of the Statistical Research Division draft report (other than to the extent included in other Divisional reports) and except in the case of the Director's Summary Report. Voluntary agencies will be invited to submit comments, in succinct written form, on any draft report affecting them. Nothing shall be published prior to such opportunity being offered.

9. Draft reports circulated by the Executive Committee to agencies — and all circulated communications prior to the final Report — will be endorsed in capital letters at the top: "This is a tentative draft, subject to correction and revision. It is circulated only for discussion purposes to those for whom intended and should not be quoted or summarized."

10. The Executive Committee (or a sub-committee) will receive and consider adverse comments submitted by agencies, and will determine with which agencies to hold conferences (whether requested or not). If an agency requests a conference upon a draft report, the Executive Committee will decide such request on its merits. At any such conference, the Executive Committee (or a sub-committee) will determine whether — in addition to the Director — other representatives of the Survey Staff shall be present and participate.

11. Agency conferences conducted by the Executive Committee (or a sub-committee) are for the purpose of receiving information and points of view which might influence the Committee. Such conferences are not judicial in nature, but for mutual guidance in developing the final Report.

12. When the Executive Committee has received the written comments of affected agencies and has concluded its conferences, it will receive the Summary Report of the Director. The Executive Committee will draft its brief report to the Committee of Citizens, transmitting the Director's Summary Report and filing the Divisional reports, together with any agency adverse comments and Executive Committee dissents (if any).

13. Following such submission, one or more meetings will be held by the Committee of Citizens to consider and act upon the Executive Committee's report. In the event that agreement is not reached at such meetings, consideration will be given to the desirability of appointing special committees of the Committee of Citizens to resolve such issues for and report back to the Whole Committee. The Survey Director, and such assistants as he may designate, shall have opportunity to appear before and be heard by the Committee of Citizens.

## ANNEX B

# Principal Agencies in the Area Covered by the Survey

## I. Planning and Financing Division

VOLUNTARY AGENCIES

Arlington Community Chest, Inc.
Associated Jewish Philanthropies, Inc.
Bedford Community Council
Belmont Community Federation
Boston Health League, Inc.
Braintree Community Chest
Burlington Community Council
Cambridge Community Council
Cambridge Community Federation
Canton Community Chest and Council
Cohasset Community Chest
Community Council of Weston
Community Federation of Watertown
Concord Community Chest
Dedham Federation, Inc.
Everett Community Chest
Greater Boston Community Council
Greater Boston Community Fund
Greater Boston Nursing Council
Hingham Community Chest
Hospital Council of Boston
Hull Community Chest and Council
Lexington Community Chest
Malden Community Chest and Council
Medfield Community Chest
Medford Community Chest-Council
Melrose Community Council
Natick Community Chest and Council
Needham Community Chest
Needham Community Council
Newton Community Chest, Inc.
Newton Community Council
Norwood Community Chest
Quincy Community Chest, Inc.
Quincy Council of Social Agencies
Reading Community Chest
Sharon Community Chest
Somerville Community Council, The
Stoneham Community Chest
Sudbury Community Chest
United Settlements of Greater Boston
Wakefield Community Chest
Waltham Community Fund, Inc.
Waltham Social Welfare Council
Wayland Community Chest
Wellesley Community Chest and Council, Inc.
Westwood Community Chest and Council
Weymouth Community Chest
Winchester Community Chest, Inc.
Woburn Community Chest

## II. Recreation and Group Work Division

VOLUNTARY AGENCIES

All Newton Music School, Inc.
Arlington Boys Club, Inc.

Beacon Hill Community Centre, Inc.
  Camp Co-No-Mo
Belmont-Watertown Jewish Community Center, Inc.
Beth Israel Center (Waltham)
Bethany Union for Young Women

Boston Baptist Bethel City Mission Society
  *Centers*
    Heath Christian Center
    Baptist Bethel
  *Camp*
    The Pond Homestead

Boston Center for Adult Education
Boston Music School, Inc., The

Boston Young Men's Christian Association
  *Branches*
    Army and Navy Branch (Charlestown)
    Boston and Maine R.R. Branch (Charlestown)
    Camping and Outdoor Recreation Branch (Huntington Ave.)
    Charlestown Branch
    Chinese Branch
    Dorchester Center Community Branch
    Greenwood Youth Center (operated jointly with the Boston YWCA)
    Huntington Ave. Branch
    Hyde Park Branch
    City-Wide Boys' Work Board (Huntington Ave.)
  *Camps*
    Camp Dee
    Camp Dorchester
    Camp Ousamequin
    North Woods Camp
    Sandy Island Camp

Boston Young Men's Christian Union
  *Camps*
    Camp Union
    Harriet Lee Hammond Memorial
    Margaret C. Bazely Memorial
    Theodora A. Luard Memorial

Boston Young Women's Christian Association
  *Program Centers*
    Central Building
    Greenwood Youth Center (operated jointly with the Boston YMCA)
  *Camps*
    Camp Gaywood
    Camp Winnecunnet
  *Residences*
    40 Berkeley Street
    The Pioneer

Boys' and Girls' Camps, Inc.
  *Camps*
    Bald Peak Caddy Camp
    Camp Lapham
    Camp Mitton
    Camp Wing
    Duxbury Stockade
    Eastwood Ho Caddy Camp
Boys' Club of Waltham, Inc.
Boys' Clubs of Boston, Inc.
  Bunker Hill Clubhouse
  Charles Hayden Clubhouse
  Roxbury Clubhouse
Boy Scouts of America, Inc.
  Algonquin Council
    Camp Resolute
  Bay Shore Council
    Camp Pow Wow
  Boston Council, Inc.
    Loon Pond Camp
  Cambridge Council
    Camp Quinapoxet (used jointly by Norumbega Council)
  Fellsland Council
    Camp Fellsland
  Norumbega Council
    Camp Nobscott
  Old Colony Council
    Camp Child
  Quannapowitt Council
    Camp Manning
  Quincy Council
    Camp Massasoit
  Sachem Council
    Camp Sachem
  Wachusett Council
    Camp Wanocksett

Brooke House
Burroughs Newsboys Foundation
  Agassiz Village (camp)

Cambridge Art Center for Children, Inc.
Cambridge Center for Adult Education
Cambridge Community Center, Inc.
Cambridge Neighborhood House
Cambridge Young Men's Christian Association
  *Camps*
    Camp Massapoag
    Caddy Camp at Oyster Harbors Golf Club

Cambridge Young Women's Christian Association
Red Barn (camp)
Camp Allen (Kiwanis Club of Boston, Inc.)
Camp Caravan, Inc.
Camp Chebacco, Inc.
Camp K of C (Knights of Columbus)
Canton Youth Committee
Catbolic Charitable Bureau of Boston, Inc.
Catherine Moore House
Emmanuel House
Vacation House
Charlotte Cushman Club of Boston
Chelsea Boys' Club
Chelsea Young Men's Christian Association
Children's Aid Association, Dept. of Neighborbood Clubs
Children's Art Centre, Inc.
Children's Museum of Boston
Children's Sunligbt Camp
Christ Child Society
City Missionary Society
*Camps*
Camp Andover
Camp Waldron
Community Center of Cohasset
Community Recreation Service of Boston, Inc.
Community Young Men's Christian Association of Reading
Council for Greater Boston Camp Fire Girls (Groups in 18 cities and towns of Greater Boston Area)
Camp Kiwanis
Country Week Association
Croagh Patrick Center
Cunningham Foundation

Davis Bates Clapp Memorial Association
Dedham Community Association, Inc.
Denison House
Camp Denison
Dorchester House, The

East Boston Social Centers Council
*Centers*
Central Square Center
Jeffries Point Boys Club
Marginal Street Center
*Camps*
Camp Cielo Celeste
Camp Nashoba
Camp Wakitatina
East End Union of Cambridge, Mass.
Ellis Memorial and Eldridge House, Inc.
Camp Wadsworth
Elizabeth Peabody House Association
Camp Gannett
Episcopal City Mission, Lincoln Hill Camp for Girls
Episcopal Department on Youth
*Camps*
Brantwood Camp
Camp Dennen
Camp O-AT-KA
Fleur de Lis Camp
Holiday House
Groton School Camp
St. Margaret's Camp
Trinity Camp, Inc.
William Lawrence Camp
Everett Jewish Community Center

Frances E. Willard Settlement, Frances E. Willard House
Franklin Square House

Girls' Clubs of Boston, Inc. (Clubs in Charlestown and Soutb Boston)
Girl Scouts, Inc., Massachusetts
*Camps*
Camp Four Winds
Camp Helen Storrow
Camp Wynona
Vineyard Sailing Camp

Girl Scout Councils or Troops in Following Cities and Towns
Arlington Girl Scouts
Camp Menotomy
Girl Scouts (Bedford)
Belmont Girl Scouts, Inc.
Boston Council of Girl Scouts
Camp Treasure Island
Girl Scouts (Braintree)
Girl Scouts Brookline Council, Inc.
Girl Scouts (Burlington)
Cambridge Girl Scouts, Inc.
Camp Weetamoe
Girl Scouts (Canton)
Girl Scouts (Chelsea)
Girl Scouts (Cohasset)
Concord, Mass. Girl Scouts, Inc.
Girl Scouts (Dedham)
Girl Scouts (Dover)
Dover Girl Scout Camp
Girl Scouts (Everett)
Hingham Girl Scout Council, Inc.
Girl Scouts (Holliston)
Girl Scouts (Hull)
Girl Scouts (Lexington)
Camp Allbridge
Girl Scouts (Lincoln)
Malden Council of Girl Scouts
Camp Cabin-in-the-Fells
Girl Scouts (Medfield)
Medford Council of Girl Scouts
Camp Tawamana
Girl Scouts (Melrose)
Girl Scouts (Millis)
Milton Girl Scouts, Inc.
Girl Scouts (Natick)
Girl Scouts (Needham)
Newton Local Council of Girl Scouts, Inc.
Camp Mary Day
Girl Scouts (North Reading)
Girl Scouts (Norwell)
Girl Scouts (Norwood)
Quincy Council, Girl Scouts, Inc.
Camp Wind-in-the-Pines
Reading Council of Girl Scouts, Inc.
Girl Scouts (Revere)
Girl Scouts (Scituate)
Sharon Girl Scouts Council, Inc.
Girl Scouts Council of Somerville, Inc.
Girl Scouts (Stoneham)
Girl Scouts (Sudbury)
Girl Scouts (Wakefield)
Walpole Council of Girl Scouts
Girl Scouts (Waltham)
Girl Scouts (Watertown)
Girl Scouts (Wellesley)
Weston Scouts, Inc.
Girl Scouts (Westwood)
Girl Scouts (Weymouth)
Girl Scouts (Winchester)
Girl Scouts (Winthrop)
Girl Scouts (Woburn)

Gray Houses, Inc.
Hano Street Community Center
Greater Boston Community Council
Camp Bureau
Neighborhood Houses and Youth Agencies Division
Good Will Neighborhood House

Hale House Association
Camp Hale
Hannah Williams Playground Association
Harriet Tubman House, Inc.
Hattie B. Cooper Community Center
Hecht House, Inc.
Hemenway House

International Institute of Boston, Inc.
International Order of tbe King's Daughters and Sons, Gordon Rest and Camp Wampatuck

Jamaica Plain Neighborhood House Association
Jewish Community Center
Jewish Welfare Board, N. E. Section of National YMHA's and YWHA's of N. E., Inc.
*Camps*
Camp Avoda
Camp Bauercrest
Camp Naomi
Junior Welfare League

Kiddie Kamp (Knights of Pythias)

Lady's Guild House
League of Women for Community Service
Lincoln House Associaton
Lincoln Vacation House
Little House

Malden Young Men's Christian Association, The
Margaret Fuller House, Inc., The
  Camp Newton
Medfield Playground Association
Medford Jewish Community Center
Morgan Memorial Coop. Industries and Stores, Inc., The
  Eliza A. Henry Home
  Lucy Stone Home
  Fresh Air Camps
Mothers' Rest Association of the City of Newton, Inc.
Museum of Fine Arts

Newton Young Men's Christian Association, Inc.
  Frank A. Day (camp)
Norfolk House Centre
North Bennet Street Industrial School, The
  *Camps*
    Boxford
    Caddy Camp
North End Union
  Camp Parker

Olivia James House, Inc.

Prospect Union Educational Exchange

Quincy Council of Camp Fire Girls
Quincy Jewish Center

Rebecca Pomroy House
Robert Gould Shaw House, Inc.
  Breezy Meadows Camp
Roxbury Neighborhood House Association
  Roxbury Neighborhoodhouse Camp

St. Helena's House
St. Mark Social Center, Inc.
Salvation Army of Mass., Inc.
  South End Boys' Club, The
  Wonderland Fresh Air Camp
Scout House, Inc.
Scoutland, Inc.
Sharon Civic Foundation
South End House Association
  *Centers*
    Main office and residence at 20 Union Park
    South Bay Union Center
    Rutland Street Center
  *Camps*
    Caddy Camp
    Winning Farm
South End Music School, The
Students House, Inc.

Trinity Neighborhood House and Day Nursery
  Trinity Camp

United Settlements of Greater Boston

Wakefield Young Men's Christian Association
Wayland Junior Town House, Inc.
Wayland Playground Association
Wells Memorial Association
West End House, Inc.
  West End House Camp
West Newton Community Center
Women's Service Club of Boston

Young Men's Christian Association (Melrose)
Young Men's Christian Association (Somerville)
  Camp at Sanbornville, N. H.
Young Men's Christian Association of Malden
Young Men's Christian Association of Quincy
  Camp at Sandwich, Mass.
Young Men's Christian Association of Woburn
Young Men's Hebrew Association (Chelsea)
Young Men's Hebrew Association of Boston
Young Women's Christian Association of Malden

PUBLIC AGENCIES

Boston Housing Authority (Recreation programs in the 8 housing projects)
Department of Public Buildings, City of Boston
*Libraries* in the 55 cities and towns of Greater Boston Area
*Park boards or departments* in the 55 cities and towns of Greater Boston Area

*Planning Boards*
  State Planning Board
  City planning boards in Boston, Cambridge, and other communities of Greater Boston Area

*Recreation Boards, Commissions, or Communities*
  Metropolitan Dist. Commission, Commonwealth of Mass. Division of Parks Engineering
  Recreation boards, commissions, or committees in 19 cities and towns of Greater Boston Area

*School Committees* in Boston, Cambridge, Newton and other communities of Greater Boston Area
  (Programs pertaining to recreation and extended use of school buildings)

## III. Voluntary Casework Division

Where hospitals, dispensaries and health agencies are listed below, the Voluntary Casework Division reviewed only social service departments and rehabilitation programs. Where neighborhood houses and settlements are listed, the Division reviewed only nursery school programs.

VOLUNTARY AGENCIES

American National Red Cross
  Bedford Chapter
  Boston Metropolitan Chapter
  Burlington Chapter
  Cambridge Chapter
  Carlisle Branch, Lowell Chapter
  Cohasset Chapter
  Concord Chapter
  Hingham Chapter
  Holliston Branch, Framingham Chapter
  Hull Chapter
  Lexington Chapter
  Lincoln Branch, Concord Chapter
  Malden Chapter
  Medford Chapter
  Melrose Chapter
  Milton Chapter
  Natick Chapter
  Needham Chapter
  Newton Chapter
  North Reading Branch, Salem Chapter
  Norwell Branch, Rockland Chapter
  Quincy Chapter
  Reading Chapter
  Scituate Chapter
  Sherborn Chapter
  Somerville Chapter
  Stoneham Chapter
  Sudbury Chapter
  Wakefield Chapter
  Walpole Chapter
  Waltham Chapter
  Wayland Chapter
  Wellesley Chapter
  Weston Chapter
  Weymouth Chapter
  Winchester Chapter
  Winthrop Chapter
Angel Guardian, The Trustees of the House of
Annah F. Osgood Home of Aged People
Arlington Social Service League, Inc.
Armstrong-Hemenway Foundation
Association of the House of the Good Samaritan
Avon Home, The

Baptist Home of Massachusetts, The
Bay State Society for the Crippled and Handicapped
Belmont Family Service, Inc.
Benoth Israel Sheltering Home
Beth Israel Hospital
Boston Aid to the Blind, Inc.
Boston Baptist Bethel City Mission Society
Boston Children's Friend Society
Boston Dispensary
Boston Episcopal Charitable Society
Boston Fatherless and Widows' Society
Boston Guild for the Hard of Hearing
Boston Industrial Home
Boston Legal Aid Society
Boston Lying-In Hospital
Boston Nursery for Blind Babies
Boston Provident Association
Boston School for the Deaf
Boston Seaman's Friend Society
Boston Service for New Americans
Boston Tuberculosis Association
  Prendergast Preventorium
  Sheltered Work Shop

Boston Young Men's Christian Union, Social Services Dept.
Brookline Friendly Society, Family Service
Burnap Free Home for Aged Women

Cambridge Community Center, Inc.
Cambridge Homes for Aged People
Cambridge Tuberculosis and Health Association
Camp Allen
Carney Hospital
Catholic Boys Guidance Center
Catholic Charitable Bureau of Boston
Catholic Charitable Bureau of Cambridge
Catholic Guild for the Blind, Archdiocese of Boston
Catholic Institute for the Deaf and Hard of Hearing
Central Hospital
Charles Choate Memorial Hospital
Chelsea Day Nursery and Children's Home
Chelsea Memorial Hospital
Children's Aid Association
  Berquist Home for Boys
  Temporary Home for Girls
Children's Hospital
Children's Mission to Children
Church Home Society for the Care of Children of the Protestant Episcopal Church
City Missionary Society
Community Workshops
Concord Friendly Aid Society
Concord's Home for the Aged

Disabled Veterans' Hospital Service
Dorchester House

East Boston Social Centers Council
Elizabeth E. Boit Home for Aged Women
Elizabeth Peahody House Association
Emerson Hospital
Episcopal City Mission
  Morville House
  Seamen's Club
Everett Home for Aged Persons
Everett House

Family Service of Malden
Family Service Bureau of Newton, Inc.
Family Society of Greater Boston
Family Society of Cambridge
Family Welfare Society of Quincy
Faulkner Hospital
Fitch Home, Inc.
Florence Crittenton League of Compassion
  Maternity Home and Hospital
  Social Service Department
  Welcome House
Frances Merry Barnard Home, Inc.
Frances E. Willard Settlement
  Ann Judson Ross Home
  Llewsac Lodge
Fredericka Home, Inc.
Free Hospital for Women
Fuller Trust, Inc.

German Ladies' Aid Society of Boston
Good Will Neighhorhood House
Greater Boston Community Council
  Family and Child Care Division
Guild of St. Elizabeth

Habit Clinic for Child Guidance, Inc.
Hale House Association
Harriet Tubman House, Inc.
Hastings House
Hattie B. Cooper Community Center
Hebrew Free Burial Association
Hebrew Home for the Aged
Hebrew Ladies Aid Society (Everett)
Hebrew Ladies Charitable Association of Revere
Hecht House, Inc.
Home for Aged Colored Women
Home for Aged Couples
Home for Aged Men
Home for Aged Methodist Women
Home for Aged People in Stoneham
Home for Aged Women
Home for Aged Women in Woburn
Home for Catholic Children
Home for Italian Children
Home of the Little Flower
Howard Benevolent Society

Industrial Aid Society
Industrial School for Crippled and Deformed Children
Infant's Hospital
International Institute of Boston, Inc.
International Order of the King's Daughters and Sons

Jamaica Plain Neighborhood House Association
James Jackson Putnam Children's Center
Jewish Big Brother Association of Boston
Jewish Family and Children's Service
Jewish Women's Health Association
Judge Baker Guidance Center

Labouré Center (formerly Columbus Day Nursery)
Ladies' Helping Hand Home for Jewish Children (Study Home)
Lawrence Memorial Hospital of Medford
League of Women for Community Service
Leland Home for Aged Women
Lend A Hand Society
Lexington Home for Aged People
Liberty Mutual Insurance Co., Rehabilitation Center
Little Sisters of the Poor, Home of, Roxbury
Little Sisters of the Poor, Home of, Somerville
Lutheran Seamen's Home

Malden Hebrew Ladies Aid Society, Inc.
Malden Home for Aged Persons
Malden Industrial Aid Society
Malden Hospital
Malden Tuberculosis and Health Association
Managers of Boston Port and Seamen's Aid Society
Maria Hayes Home for Aged Persons
Massachusetts Association for Promoting the Interests of the Adult Blind
Massachusetts Catholic Woman's Guild,
  St. James Branch No. 17
Massachusetts Eye and Ear Infirmary
Massachusetts General Hospital
Massachusetts Home
Massachusetts Memorial Hospitals
Massachusetts Society for Aiding Discharged Prisoners
Massachusetts Society for the Prevention of Cruelty to Children
  Central Office
  South Middlesex District
  South Norfolk District
  South Shore District
  Children's Home
Maverick Dispensary of East Boston
Medford Home for Aged Men and Women
Middlesex Health Association
Milton Visiting Nurse and Social Service League
Morgan and Dodge Home for Aged Women
Morgan Memorial Cooperative Industries and Stores, Inc.
  Charles Hayden Goodwill Inn for Boys
  Day Nursery
  Fred H. Seavey Settlement
  Goodwill Workshops
Mount Auburn Hospital
Mount Pleasant Home

Needlewoman's Friend Society
New England Baptist Hospital
New England Deaconess Hospital
New England Epilepsy League
New England Home for Deaf Mutes
New England Home for Little Wanderers
  Longview Farm
  Study Home
New England Hospital for Women and Children
New England Peabody Home for Crippled Children
New England Sanitarium and Hospital
Newton Catholic Welfare Committee
Newton Tuberculosis and Health Association
Newton-Wellesley Hospital
Norfolk County Health Association
Norfolk House Centre
North Bennet Street Industrial School
North End Union
Norwegian Old People's Home and Charitable Association of Greater Boston
Norwood Hospital

Old Ladies' Home Association of Chelsea
Olivia James House
Orchard Home School

Perkins Institution and Massachusetts School for the Blind
Peter Bent Brigham Hospital

Quincy Catholic Charities
Quincy Salvation Army

Reading Home for Aged Women
Rebecca Pomroy House
Resthaven Corporation
Robert Breck Brigham Hospital
Robert Gould Shaw House, Inc.
Roxbury Home for Aged Women
Roxbury Neighborhood House Association
Rufus F. Dawes Hotel
Ruggles Street Nursery School
Rutland Corner House

St. Elizabeth's Hospital of Boston
St. Joseph's Home
St. Lukes' Home for Convalescents
St. Mary's Infant Asylum and Lying-In Hospital
St. Vincent's School
Salvation Army of Massachusetts, Inc.
  Family Service Bureau
  Men's Social Center
  Booth Memorial Hospital
Sarah Fuller Foundation for Little Deaf Children
Shut-in Society, Inc., Massachusetts Branch
Social Service Board of Dedham, Inc.
Social Service League of Cohasset
Society of St. Vincent de Paul, Particular Council of Boston
  (includes 115 local parish units or conferences)
  Salvage Bureau
Somerville Catholic Charities Centre
Somerville Family Service Association
Somerville Home for the Aged
Somerville Hospital
South Boston Samaritan Society
South End Day Nursery
South End House Association
South Shore Hospital
Stone Institute and Newton Home for Aged People
Sunnyside Day Nursery
Swedish Charitable Society of Greater Boston
Symmes-Arlington Hospital

Travelers' Aid Society of Boston, Inc.
Trinity Church Home for the Aged
Trinity Neighborhood House and Day Nursery

United Moeth Chitim Association
United Prison Association of Massachusetts

Voluntary Defenders Committee, Inc.

Waltham Family Service League
Waltham Hospital
Washingtonian Hospital
Watertown Home for Old Folks
Wellesley Friendly Aid Association
Weymouth Family Service Society, Inc.
Whidden Memorial Hospital
Widows' Society of Boston
William B. Rice Eventide Home
Winchester Home for Aged People
Winchester Hospital
Winthrop Community Hospital
Winthrop Hebrew Ladies Auxiliary
Women's Educational and Industrial Union
  Bureau of Occupations for Handicapped Women
Working Boys' Home

Because of the close relationship between the programs of certain public and voluntary agencies, the following public agencies were reviewed in this Division:

PUBLIC AGENCIES

*Boston, City of*
  Boston City Hospital
    Sanatorium Division
  Boston Juvenile Court
    Citizenship Training Department
  Institutions Department
    Long Island Hospital Division
  School Committee
    Bureau of Child Accounting
    Horace Mann School for the Deaf

*Cambridge, City of*
  Cambridge City Hospital
  Cambridge Sanatorium

*Massachusetts, Commonwealth of*
  Board of Probation
  Department of Correction, Parole Board
  Department of Education
    Division of the Blind
    Division of Vocational Rehabilitation
  Department of Labor and Industries
    Division of Employment Security
  Department of Public Health
    Sanatoria
      Lakeville State Sanatorium
      North Reading State Sanatorium
      Rutland State Sanatorium
  Department of Public Welfare
    Division of Child Guardianship
    Division of Juvenile Training
    Institutions
      Industrial School for Girls
      Lyman School for Boys
      Massachusetts Hospital School

*Middlesex County*
  Middlesex County Courts
    Juvenile Probation Service
  Middlesex County Sanatorium
  Middlesex County Training School

*Norfolk County*
  Norfolk County Courts
    Juvenile Probation Service
  Norfolk County Hospital

*Plymouth County*
  Plymouth County Courts
    Juvenile Probation Department

*Quincy, City of*
  Quincy City Hospital

*Suffolk County*
  Suffolk County Courts, probation service

School Committees in 54 cities and towns of Metropolitan Area. (Programs of child accounting, child guidance, and rehabilitation)

## IV. Health Division

VOLUNTARY AGENCIES

American Cancer Society
American National Red Cross
Arlington Visiting Nursing Association, Inc.
Bay State Society for the Crippled and Handicapped
Belmont Community Nursing Association
Belmont Nutrition Council
Boston Health League, Inc.
Boston Tuberculosis Association
Braintree Visiting Nurse Association
Brookline Anti-Tuberculosis Society, Inc.
Brookline Friendly Society, The Health Center and
  Visiting Nurse Service
Cambridge Tuberculosis and Health Association
Cambridge Visiting Nursing Association
Canton Nursing Association
Chelsea Visiting Nurse Association
Community Workshops, Inc.
Concord Visiting Nurse Association
Dedham Visiting Nursing Association
Epilepsy League of New England, Inc.
Everett Visiting Nurse Association
Forsyth Dental Infirmary for Children
Greater Boston Community Council
  Health and Hospital Division
Greater Boston Nursing Council
Boston Household Nursing Association
Hingham Visiting Nurse and Community Service, Inc.
Lexington Visiting Nurse Association
Malden Children's Health Camp Association, Inc.
Malden Industrial Aid Society,
  (Community Nursing Service)
Malden Tuberculosis and Health Association
Massachusetts Central Health Council
Massachusetts Society for Mental Hygiene
Massachusetts Society for Social Hygiene, Inc.
Massachusetts Tuberculosis League, Inc.
Medford Visiting Nursing Association
Massachusetts Public Health Association
Middlesex Health Association
Millis Visiting Nurse Association

Natick Visiting Nurse Association
National Foundation for Infantile Paralysis, Inc.
Needham Dental Clinic
Needham Visiting Nurse Association
New England Heart Association
Newton District Nursing Association
Newton Nutrition Center
Newton Tuberculosis and Health Association
Norfolk County Health Association, Inc.
Norwell Visiting Nurse Association
Norwood Visiting Nurses Association
Plymouth County Health Association
Reading Visiting Nurse Association, Inc.
Revere Visiting Nurse Association, Inc.
Scituate Public Health Nursing Service
Social Service League of Cohasset
Stoneham Visting Nurse Association
Sudbury Public Health Nursing Association
Visiting Nurse Association of Boston
Visiting Nurse Association of Dover, Medfield, and Norfolk
Visiting Nurse Association of Somerville
Wakefield Visiting Nurse Association
Walpole Visting Nurse Association
Waltham District Nursing Association
Watertown District Nursing Association
Wellesley Friendly Aid Association, Inc.
Westwood Community Health Association
Weymouth Visiting Nurse Association, Inc.
Winchester District Nursing Association
Winthrop Visiting Nurse Association, Inc.
Woburn Visiting Nurse Association, Inc.

PUBLIC AGENCIES

Boards of health or health departments and school health programs in the 55 cities and towns of the Greater Boston Area.

Tuberculosis sanatoria of Boston and Cambridge

Commonwealth of Massachusetts
- Department of Education
  - School Health
  - Vocational Rehabilitation
- Department of Mental Health
- Department of Public Health
- Division of Vital Statistics
- State Sanatoria at Lakeville, North Reading, Pondville, Rutland, Westfield.

## V. Hospital Division

Allerton Hospital
Audubon Hospital
Bay State Hospital
Bellevue Hospital
Beth Israel Hospital
Booth Memorial Hospital
Boston City Hospital
Boston Dispensary
Boston Evening Clinic and Hospital
Boston Home for Incurables
Boston Floating Hospital
Boston Lying-In Hospital
Brooks Hospital
Cambridge City Hospital
Carney Hospital
Central Hospital
Charles Choate Memorial Hospital
Chelsea Memorial Hospital
Chester Hospital
Children's Hospital
Cohasset Hospital
Convalescent Home for Children
Emerson Hospital in Concord
Faulkner Hospital
Florence Crittenton League of Compassion Maternity Home and Hospital
Free Hospital for Women
Glover Memorial Hospital
Glynn Hospital
Hahnemann Hospital
Harley Hospital
Hastings House
Holy Ghost Hospital
House of the Good Samaritan
Hull Hospital
Infants' Hospital
Jamaica Plain Dispensary
Jewish Memorial Hospital
Joseph H. Pratt Diagnostic Hospital
Kenmore Hospital
Lawrence Memorial Hospital
Leonard Morse Hospital
Long Island Hospital
Longwood Hospital
Malden Hospital, Inc.
Massachusetts Eye and Ear Infirmary
Massachusetts General Hospital
Massachusetts Lying-In and General Hospital
Massachusetts Memorial Hospitals
Massachusetts Osteopathic Hospital
Massachusetts Women's Hospital
Maverick Dispensary
Medical Mission Dispensary
Melrose Hospital Association
Milton Hospital and Convalescent Home
Mount Auburn Hospital
New England Baptist Hospital
New England Deaconess Hospital
New England Hospital for Women and Children
New England Peabody Home for Crippled Children
New England Sanatorium and Hospital
Newton-Wellesley Hospital
Norwood Hospital
Otis Hospital
Peter Bent Brigham Hospital
Quincy City Hospital
Revere Memorial Hospital
Robert Breck Brigham Hospital
St. Elizabeth's Hospital
St. Margaret's Hospital and St. Mary's Infant Asylum
Sancta Maria Hospital
Somerville Hospital
South Shore Hospital
Sunnyside Hospital
Symmes-Arlington Hospital
Tewksbury State Hospital
Waltham Hospital
Washingtonian Hospital
Whidden Memorial Hospital
Winchester Hospital
Winthrop Community Hospital
Wolfson Nose and Throat Hospital

## VI. Public Welfare Division

Administration of public assistance was studied in the following towns and cities:

| | |
|---|---|
| Braintree | Natick |
| Concord | Quincy |
| Everett | Reading |
| Hingham | Scituate |
| Holliston | Somerville |
| Hull | Wakefield |
| Malden | Walpole |
| Melrose | Watertown |
| Milton | Winchester |

# ANNEX C

# List of Professional Staff in the Divisions of the Survey

Robert P. Lane, *Director of Survey*, former Executive Director, Welfare Council of New York City

## I. Planning and Financing Division

### PANEL OF CONSULTANTS

*Name and Permanent Position*

Herman D. Smith
Vice President
Marsh & McLennan, Inc.
Chicago, Illinois.
Former President of Social Agencies of Chicago
Former Chairman, Budget Committee, Community Chest of Chicago.
Now Vice President of both the Council and the Chest in Chicago
*Survey Assignment* — Chairman of the Panel

John B. Dawson
Executive Director
Health and Welfare Council, Inc.
Philadelphia, Pennsylvania
*Survey Assignment* — Council Consultant

Robert H. MacRae
Managing Director and Secretary
Community Chest of Metropolitan Detroit
Detroit, Michigan
*Survey Assignment* — Chest Consultant

## II. Recreation and Group Work Division

Lewis R. Barrett, Director of the Division
Recreation Consultant
New York City

### COMMITTEE OF NATIONAL CONSULTANTS

W. Noel Hudson, Chairman
Executive Vice-President
Federation of Protestant Welfare Agencies, Inc.
New York City

F. Ellwood Allen
President, F. Ellwood Allen Organization
Recreation Consultants
New York City

Grace Coyle
School of Applied Social Sciences
Western Reserve University
Cleveland, Ohio

N. S. Light
Director, Bureau of School & Community Services
State Department of Education
Hartford, Connecticut

John McDowell
Executive Secretary
The National Federation of Settlements
New York City

Caswell W. Miles
Supervisor, Physical Education & Recreation
The University of the State of New York, State Edu. Dept.
Albany, New York

Helen Rowe
Camp Fire Girls
New York City

Arthur L. Swift, Jr., Ph.D.
Union Theological Seminary
New York City

### LOCAL ADVISORY COMMITTEE

Robert Rutherford, Chairman
Secretary, Neighborhood Houses and Youth Agencies Div.
Greater Boston Community Council

Arthur T. Burger, Boys' Clubs of Boston
Claire Fisk, United Settlements of Greater Boston and Greater Boston Comm. Council
Doris E. V. Foster, Camp Fire Girls, Council of Greater Boston
O. Ricker Freeman, Boston Park Department
Rex I. Gary, Boy Scouts of America, Boston Council
O. T. Gilmore, Greater Boston Community Council
Ray Johns, Boston Young Men's Christian Association
Alvin G. Kenney, Community Recreation Service
Thomas McCormick, Boston Planning Board
Joseph McKenney, Boston School Committee, Physical Education Department
Mary E. Mooney, Olivia James House
William P. Mullen, Boston Park Department
James T. Mulroy, Boston School Committee, Department of Extended Use of Public Schools
W. Duncan Russell, Greater Boston Community Council
Marcia Seeber, Boston Young Women's Christian Association
Frederick J. Soule, Norfolk House Center
Thomas T. Turley, South End House Association
Marjorie C. Warren, Children's Aid Association

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Margaret Kelley
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## III. Voluntary Casework Division

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*Survey Assignment* — Consultant on Rehabilitation

## IV. Health Division

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Chairman, Department of Public Health
Yale University, New Haven, Connecticut

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## V. Hospital Division

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*Name and Permanent Position*

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## VII. Statistics Division

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James J. Sullivan
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Boston, Massachusetts
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# DIRECTOR'S FOREWORD

The Greater Boston Community Survey has no precedent in this country. Other social and health surveys have covered as extensive an area, have been concerned with as large a population, and may have dealt with as many agencies or embraced as many governmental jurisdictions. But no community survey has combined all of these elements, and added still others, in the manner that makes this Survey unique.

*A Survey Set Apart*

In the cities and towns of Greater Boston are found some of the country's oldest voluntary agencies, a few of them with some of the country's largest capital reserves; agencies established and for decades supported by persons bearing names that are honored throughout the country. Here are agencies that march in the forefront of advancing professional practice. Here are agencies that were once distinguished pioneers in important fields, still unforgetful of their early glory. Here are some of the newest and some of the oldest methods, and certainly some of the most tenacious traditions, in American public welfare and public health. Here, in these independent, self-governing communities, are found a local pride, a resistance to outside control, a determination to manage one's own affairs, that are the very pith of the American spirit. Tax-supported and voluntary alike, the social and health agencies of Greater Boston present both an unparalleled opportunity and an unparalleled challenge to any group of lay citizens and professional workers who undertake a survey of this ancient, complex and justly proud community.

At least one other circumstance sets this Survey apart. Nearly all community surveys follow a fairly familiar pattern. This pattern calls for organization of a local survey committee; preparation of reports by survey staff members; limited consultation between the survey staff and the survey committee; limited opportunity for "affected agencies" to comment on survey findings before they are published; and eventual issuance of the reports on *virtually the exclusive responsibility of the survey staff*. The pattern of the Greater Boston Community Survey has been quite different. Here the members of the Survey Executive Committee, sixteen exceptionally busy men and women, have weighed every word of the thousand-odd pages of our Divisional Reports and this Summary Report. The Executive Committee, acting as a whole and not through subcommittees, has repeatedly met with the staff divisional directors and associate directors, has considered with them every phase of every Divisional Report, and in the few instances where there was a difference of opinion the dissent of the Executive Committee from the findings of the staff is fully set forth. Tentative drafts of the reports as thus agreed on have been sent to the hundreds of affected agencies; and on the basis of written comments from more than 126 of these agencies, and conferences with representatives of 49, countless changes in wording and a great many changes in substance have been introduced.* Among all social and health surveys, this procedure cannot be matched as an example of the democratic spirit in action.

*Instructions to the Staff*

In selecting a staff for this Survey, I was charged to get the most competent specialists in the country. The full list of staff members on pages xiv-xvi shows how successfully that charge was carried out. As the Chairman of the Committee of Citizens has stated in his *Brief Historical Account*, we were advised at the start that the object of the Survey was "to make sure that the charitable dollar annually raised in Greater Boston does the greatest good for the greatest number in the most economical, effective way." We were admonished to avoid generalities and technical language, and to make our recommendations impartial and incisive. On our behalf it was pledged in advance that our reports would contain, where needed, "specific recommendations for improvement, strengthening, enlargement, consolidation, curtailment, or elimination in regard to fields of service, relationships, and individual agencies." Apart from these general but sweeping instructions, the staff was left wholly free. Obviously such instructions and such freedom laid upon us a heavy professional and moral responsibility, which we have done our utmost to discharge.

One freedom which the staff enjoyed is worthy of special note. The whole purport of our instructions was that the health and welfare services of Greater Boston belong to the people of Greater Boston. It was not suggested that our reports show only how existing agencies could be improved. The effective and economical rendering of service was to be our sole aim. By setting this high aim, the Committee of Citizens went as far as it could in leaving us unhampered to make our own diagnosis and write our own prescription. We could not be wholly unhampered. No community, least of all a community as old and populous as Greater Boston, offers a blank page. Nor would we wish a blank page, for there is much work here of high distinction which should be conserved and built on.

*At the end of the Foreword are listed the agencies with whom conferences were held and the agencies the written comments of which were, in some part at least, not incorporated in the respective final Divisional Reports.

*Methods Followed by the Staff*

In approaching our task, we found it necessary at the outset to accept certain definitions and to adopt certain rules of procedure, some of them in the nature of self-denying ordinances. The geographic area of the Survey was stated to be Greater Boston. For our purposes, Greater Boston comprises those cities and towns with the public and voluntary agencies, or federations of agencies, of which the Greater Boston Community Council has a formal relationship. There are 55 such cities and towns, of which 48 fall within the recognized field of solicitation of the Greater Boston Community Fund. We included tax-supported agencies, for tax-supported agencies not only spend more money and serve more people than all voluntary agencies combined, but they provide basic health and welfare services without which, in nearly every field, existing voluntary agencies would find themselves rootless and relatively unavailing. Had we not studied tax-supported agencies, our picture would have been far from complete and our recommendations seriously out of perspective. And we decided at the start, considering that we were dealing with more than 500 voluntary and 300 public bodies, that we could not assume to pass on the quality of work done by each of them, but must confine ourselves almost wholly to problems of function, organization and relationships. By this decision we hoped to be able to recommend a sound *structure* of services that would operate more economically and effectively than the present services, which are largely the product of uncoordinated historical forces. A sound structure should make future improvement in the quality of agency services much easier and more certain.

The methods we employed differed in only one particular from those employed in more conventional surveys. The decision *not* to pass on the quality of work done by each agency relieved us of much of the visiting, observation and reading of records that is called for in surveying a single agency or group of agencies. The Executive Committee rightly determined that a qualitative survey of 800 agencies would have been so expensive and time-consuming as to defeat its purpose.

Our first step was to assemble and analyze statistical data on such matters as the income and expenditures of agencies, their facilities, and the number and kinds of persons they serve. Much of this information was already available in the files of the Greater Boston Community Council and the Greater Boston Community Fund, in agency reports and in government records. The balance was collected through general questionnaires sent to all agencies and special questionnaires prepared for selected groups of agencies. A second step was to read, digest and compare descriptions of the work that agencies were doing. A great deal of such descriptive material lay ready to our hands; some of it we asked to have currently drawn up as our work progressed and gaps in our knowledge were revealed. From this statistical and descriptive material we could begin to get an understanding of the amount, the distribution and the kind of work going on. This understanding was refined in two ways — by the reading of studies previously made and by personal interviews. Committees of both Council and Fund, and especially the Research Bureau of the Council, provided many admirable studies of fields of work, of single agencies, and of groups of agencies carrying on similar or related activities. And our interviews seemed endless — with Board members, staff members, large and small local advisory groups, and people outside the Area who possessed wide experience and recognized standing, or special knowledge of conditions in Greater Boston, or both. A vast amount of talking goes into the field work of any survey.

Finally, the knowledge thus gained was subjected to the last and most important process of all, the application of critical judgment by the members of our staff. An army of surveyors could spend a dozen years in assembling facts about Greater Boston's social and health needs and services. There comes a time when the sheer piling up of information must stop and recommendations must be formulated. It is by the *quality of judgment* brought to bear that all survey recommendations stand or fall. Having sought the best men and women we could find for the staff of this Survey, we are confident that their joint and several judgment will contribute powerfully to realizing the purposes of those citizens of Greater Boston who conceived, financed, and have led this momentous undertaking.

*Staff Point of View*

Perhaps the most important thing about any survey is the point of view or set of preconceptions held by the survey staff; certainly it is important that those preconceptions be stated and understood. The staff of the Greater Boston Community Survey accepts the prevailing theory that "society" has an obligation to see that certain basic needs of people are met: needs for food, clothing, and shelter; for certain preventive health services and medical care; for minimum amounts and kinds of recreation and group experience; for counseling and guidance in relation to various kinds of personal and family problems that threaten or actually produce personal or family disorganization. To discharge this obligation, society sets up agencies of many kinds — some tax-supported and operated by units of government, some supported by voluntary funds and operated under private auspices (sectarian and

non-sectarian). Our first preconception is this: Whatever the source of funds and whatever the auspices of such agencies, they are engaged on a common task for the benefit of all the people and the services they render should be viewed as parts of a unified program.

Today it is conventional to say that parts of this program should be the responsibility of government, and even to allocate some of those parts to the federal government, some to the State government, and some to local government; and to say that other parts should be the responsibility of voluntary agencies. Yesterday the distribution of such responsibility was different, and tomorrow it may be different again. The allocations of responsibility change not only from country to country but within the same country from period to period. The present staff naturally adopts the allocations of responsibility generally adopted throughout the United States of America at the present time. Our second preconception is this: It is essential that governmental agencies acknowledge and fully discharge their statutory responsibilities; and it is in the best interests of Greater Boston to avail itself of all the financial assistance from the federal and State governments which federal and State laws make possible. In this way voluntary agencies can be freed to do what they can do best — refine, supplement and extend the work of tax-supported agencies, and often experiment with methods which tax-supported agencies later adopt. The role of voluntary agencies is a precious element in the American way of life.

*Nature of Reports*

Our Survey reports are of three major kinds. (i) Within each Division of the Survey, specialized reports were prepared by members of the Division staff. These detailed reports dealt with various aspects of the field covered by the Division and were often of very considerable length. All such reports have been filed with the Research Bureau of the Greater Boston Community Council and may be consulted there. (The same is true of the working material on which those reports are based — original questionnaires, work sheets, tables that may or may not have been used in the full Divisional Reports, records of interviews, etc.) (ii) Based upon, and in summarization or outline of these long specialized reports, Division Directors and their immediate associates put together Division Reports. All Divisional Reports, as finally approved by the Survey Executive Committee, have been reproduced in limited quantity, circulated to the agencies concerned, and filed with the Greater Boston Community Council, where they will be available for use by planning committees and other persons or groups who wish to work with them. (iii) Last, there is this Summary Report, which is essentially a condensation and consolidation of the Divisional Reports.

In the Summary Report, recommendations made in the Divisional Reports have been analyzed and certain "principles of action" are set forth which we think should guide the further planning and promotion required to put the recommendations into effect (Part Two). Each "principle of action" is illustrated with material drawn from the Divisional Reports. The Divisional Reports are then presented in condensed form (Part Three). To the material thus drawn from the Divisional Reports have been added a few chapters dealing with subjects that concern all Divisions. Chief among these added chapters are a discussion of the nature of the Greater Boston Area; a discussion of total health and welfare expenditures within the Area; a discussion of some aspects of personnel and other agency practices into which we thought it advisable to look; and a suggested set of priorities of need. These priorities are put forward on my own responsibility as Director of the Survey. If to suggest such priorities seems either presumptuous or hazardous, or both, I can only say that the dark financial picture drawn by the Chairman, in his *Brief Historical Account*, makes clear how imperative it is that some set of priorities be agreed on. Those here suggested are offered as a first step in that direction.

Of all these reports it should be said, as the reader will at once observe, that they pay more attention to weaknesses in existing services than to the strengths of those services. This emphasis does not mean that our staff failed to recognize the large amount of excellent work being done by agencies in Greater Boston. It means rather that what is true of all surveys is true of this one — it was undertaken for the purpose of effecting improvement; and improvement is more readily effected by having weaknesses pointed out and ways of remedying them suggested, than by having satisfactory practices praised. Had we devoted as much space to discussion of what we approve as we devote to what we think should be changed, our reports would be twice their present length — a result no one would enjoy.

*A Word of Appreciation*

In an enterprise so widespread, so involved, so intimate, and so prolonged as this Survey, it is obvious that no group of visitors could even partially succeed without the encouragement and active help of unnumbered people who have long been on the scene. Such encouragement and help the Survey staff has received at every turn. It is neither perfunctory courtesy nor exaggeration to say we have

never known a group of volunteer citizens who would work as hard or as long at a community survey, or who could be as helpful, as the sixteen members of this Survey Executive Committee have been. Probably no one but the Director of the Survey knows how much the entire enterprise owes to the initiative, the drive, the vision, the grasp, and the infinite capacity for taking pains constantly manifested by Mr. Cutler; he has been an inspiration and a source of unwavering support from the very outset. Officers and staff of Council and Fund have put long periods of time and the very great knowledge and wisdom of their organizations at our disposal. Agency board and staff members and score of government officials have been cooperative to a man. Where so much has been received from so many, we feel helpless to convey an adequate sense of our appreciation. This heartfelt word for all will have to suffice.

I stress, though I cannot stress enough, the manifold assistance we have received, because the nature and extent of that assistance give us faith our reports will be of value to Greater Boston. Too many survey reports are written to gather dust on a shelf. We misjudge the temper of Greater Boston if our reports do not fare far differently and far better. We believe the citizens of Greater Boston to be devoted to their social and health services, and greatly aroused. We hope they are. Only a combination of those two emotions can generate the energy and courage required to make the changes that seem to us necessary.

For it cannot be said too strongly that, while survey reports propose, it is the community itself that must dispose. The hardest part of a survey begins when the reports are finished and accepted. The survey submits a program, charts a course, points an objective: it looks exclusively to action that must be cooperatively taken by people of good will in the future. Any survey worth making contains some recommendations that cut deep and many recommendations that take years to carry out. Responsibility for seeing the job through can rest only with local citizens who have the confidence of the community and are willing to stick to the job. It is because we believe Greater Boston has many leading citizens of precisely that kind that we submit our reports, not merely with appreciation of the opportunity we have enjoyed, but with the conviction that they will bear fruit.

R. P. L.

## WRITTEN COMMENTS SUBMITTED BY AGENCIES RESPECTING TENTATIVE DIVISIONAL REPORTS, CIRCULATED DURING NOVEMBER AND DECEMBER, 1948, and JANUARY, 1949

In accordance with Survey policy, agencies were invited to submit written comments with reference to the tentative drafts of Divisional Reports which were circulated to them. Written comments, containing valuable suggestions and information, were received from 126 agencies; and these written comments are filed with the respective final Divisional Reports (lodged with the Greater Boston Community Council) to which they refer. A great deal of the material contained in these written comments appeared to be sound, was agreed to, and has been incorporated in the respective final Divisional Reports. However, other portions of such written comments were not agreed to or, whether agreed to or not, did not seem to merit inclusion. There are listed below, by Divisional fields, the names of agencies which submitted written comments which were, to some extent at least, not incorporated in the respective final Divisional Reports.

(1) **Health Division:**
Visiting Nurse Association of Boston; Housing Association of Metropolitan Boston; Greater Boston Nursing Council; Cambridge Tuberculosis and Health Association.

(2) **Hospital Division:**
Greater Boston Nursing Council; Hastings House; Hospital Council of Boston; Maverick Dispensary; Washingtonian Hospital.

(3) **Planning and Financing Division:**
United Settlements of Greater Boston; Cambridge Community Federation; Community Council of Weston.

(4) **Group Work & Recreation Division:**
All Newton Music School; Community Recreation Service Inc.; Lincoln House Association; Park Commission of the City of Boston; South End Music School; South End House; Boston YWCA; Norfolk House Centre; West Newton Community Centre; Burroughs Newsboys Foundation; Olivia James House; Children's Art Center; Girls' Clubs of Boston Inc.; Elizabeth Peabody House; Dedham Community Association; North Bennet Street Industrial School; North End Union; Boston Music School; Ellis Memorial; Cambridge Community Center; United Settlements of Greater Boston; Margaret Fuller House; Arlington Boys' Club; East End Union; Cambridge Neighborhood House; Trinity Neighborhood House; Boys' Clubs of Boston; Boston YMCU; International Institute; Children's Aid Association; East Boston Social Centers Council; Boston YMCA

(5) **Public Welfare Division**
None

(6) **Voluntary Casework Division:**
Boston YWCA; Greater Boston Community Council; Children's Aid Association Inc.; Morgan Memorial; American Red Cross; International Institute; Belmont Family Service; Women's Educational and Industrial Union; Lend-a-Hand Society; Industrial Aid Society; Family Society of Cambridge; Social Service Index; Boston School Committee; Catholic Boys' Guidance Centre; Florence Crittenton League of Compassion; Mass. S.P.C.C.; Boston Guild for Hard of Hearing; Community Workshops; Brookline Friendly Society; Family Service Bureau of Newton Inc.; Weymouth Family Service Society; Boston Industrial Home Inc.; Massachusetts Eye & Ear Infirmary; Boston YMCA; Society of St. Vincent de Paul; Hastings House; Arlington Social Service League; Catholic Charitable Bureau of Boston, Inc.

## EXECUTIVE COMMITTEE CONFERENCES WITH AGENCY REPRESENTATIVES

**December 13** . . . Little House; Norfolk House; Denison House; Jamaica Plain House; West End House.

**December 14** . . . West Newton Community Centre; Wells Memorial Association; South End House; Burroughs Newsboys Foundation; YWCA; South End Music School.

**December 16** . . . Greater Boston Community Council; Hospital Council of Boston; Health League of Boston; Nursing Council; United Settlements of Greater Boston.

**January 3** . . . . Women's Educational and Industrial Union; Morgan Memorial; Lend-a-Hand Society; Shut-in Society; Industrial Aid Society; South End Day Nursery; Children's Aid Association; Church Home Society; Waltham Family Service; Cambridge Family Service; Somerville Family Service; Family Society of Greater Boston.

**January 13** . . . . Goodwill Neighborhood House; Boston Park Department; Community Recreation Service Inc.; Elizabeth Peabody House; Gray Houses Inc.; Dedham Community Association; North Bennet Street Industrial School; Girls' Clubs of Boston; North End Union; Boston Music School; Children's Museum; Ellis Memorial.

**January 14** . . . . Hospital Council; Boston Juvenile Court.

**January 18** . . . . Hastings House; Maverick Dispensary.

**January 19** . . . . New England Home for Little Wanderers; Lincoln House and other South End Settlement and Neighborhood Houses.

**January 21** . . . . Public Welfare Department of the Commonwealth of Massachusetts; East Boston Social Centers Council.

# PART ONE

## I. The Greater Boston Survey Area

Greater Boston is one of the oldest, most densely populated, most highly industrialized and wealthiest metropolitan centers in the United States. Greater Boston is a leading educational center and a medical center of international reputation. Renowned for business acumen and cultural achievement, the leaders of Greater Boston early exhibited deep interest in human problems, sympathetic understanding of them, and great energy in trying to solve them. But just what is Greater Boston?

*Greater Boston as a Physical Unit*

There is no single Greater Boston. It exists neither as a governmental unit nor as a universally accepted number of cities and towns clustering about Municipal Boston. Eighty-three cities and towns form the Boston Metropolitan Census District. Forty-three cities and towns form the Metropolitan Boston to which the Metropolitan District Commission provides water, sewerage and park services. There are scores of other Greater Bostons, each serving its own special purpose, but all with a common core of Municipal Boston and immediately adjacent communities.

For purposes of social planning, the Greater Boston Community *Council* has established formal relations with voluntary and public agencies, or federations of agencies, in Municipal Boston and 54 contiguous cities and towns. It is this Area with which the Greater Boston Community Survey has concerned itself, and which is therefore the Greater Boston of this report.

Within this Greater Boston, the Greater Boston Community *Fund* recognizes 48 cities and towns as a field for its solicitation. The Fund's relations with these 48 communities vary. In some there are local community chests that join the Greater Boston Community Fund in a common campaign; in others there are no local chests, and solicitation is carried on directly by the Greater Boston Community Fund. The accompanying map shows the scope and diversity of these Council-Fund relations.

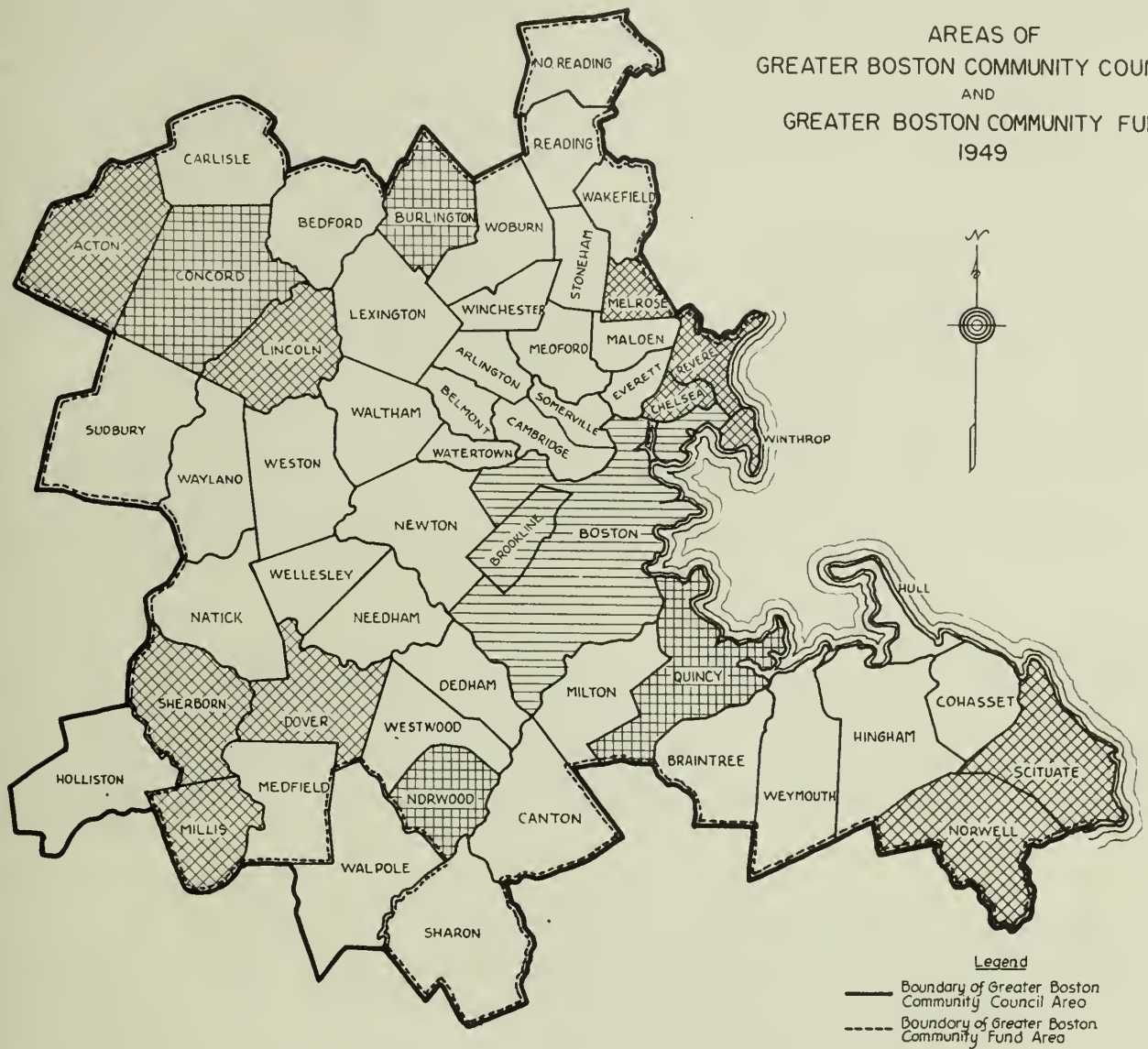
The Greater Boston of the Survey stretches north, west and south from Municipal Boston to a distance of from 15 to 25 miles; eastward lies salt water. This Greater Boston covers 700 square miles, of which only 44 lie within Municipal Boston.

Boston, as everyone knows, is an old city, first settled in 1630. Old, too, are the cities and towns which make up the rest of Greater Boston. Between 1630 and 1644 the Massachusetts Bay Colony established 12 independent towns; their boundaries encompass an area which through the years has become divided into 60 municipalities surrounding Boston. It is of many of these communities and others like them, with their separate political and economic roots extending back into the colonial period, that Greater Boston is composed. Some retain the village atmosphere and the forms of town government of earlier days. Some have grown into industrialized cities whose historical background is evidenced chiefly by an old churchyard or an occasional historical marker. Each, however, remains a separate municipal unit with a strong and consciously cherished heritage of self-reliance and independence.

*Relations of Boston to the Rest of Greater Boston*

With their origins and histories independent of Municipal Boston, the other towns and cities of Greater Boston have sustained relations to that city quite different from those existing between most large American cities and suburbs which have come into being as the outgrowth and overflow of the central city. One difference is that Boston has not grown as rapidly nor become as large as have other urban areas. Brookline and Chelsea broke off from Boston in the early 1700's and annexations to Boston did not begin until 1804, when South Boston became part of Boston. Not until between 1854 and 1874 did Roxbury, Charlestown, Brighton and West Roxbury become part of Boston. Since then only Hyde Park has voted to join Boston, in 1912. Thus, whereas Chicago has grown from an area of 4 square miles to 205, Philadelphia from 2 to 128, and Los Angeles from 28 to 459, Municipal Boston's original 1¼ square miles have increased to only 44.

For two centuries, two strong and contrary influences have been at work in Greater Boston. One influence is toward a jealously guarded political independence of its separate parts. The other is toward a growing commercial and industrial unity and increasing cooperation for specific purposes among the communities of Greater Boston.




GREATER BOSTON
COMMUNITY SURVEY
2-1-49

*Governmental and Other Administrative Relations*

Governmental and other administrative relationships in the Area are exceedingly complex. In local government, the 55 separate political jurisdictions of the Survey's Greater Boston consist of 11 cities with mayors and boards of aldermen or city councils, and 44 towns (townships) which retain the town form of government brought down from colonial days. Towns have no single elected executive head; the principal elected body is a board of selectmen, and the open town meeting where any citizen may speak his mind still flourishes. Some of the towns are larger in population than some of the cities; Brookline, for example, with its 57,000 people, remains a town, while Woburn, with a population of not quite 20,000, is a city.

Greater Boston embraces all of one county and parts of three others. The county, it should be noted, is a much less important governmental unit in New England than in most other parts of the country, and the county area does not form the basis of organization for many endeavors, commercial or governmental.

For purposes of administration, the various departments of the State government have divided the Commonwealth into districts which serve their departmental needs but conform to no regular pattern of political boundaries. There are the health districts of the Department of Public Health; the welfare districts of the Department of Public Welfare; and the hospital districts of the Department of Mental Health. The districts of the different departments are at variance with each other, so that the communities of Greater Boston are grouped differently according to the department concerned.

Still different administrative groupings occur under such important regional agencies as the Metropolitan District Commission; the Metropolitan Transit Authority; the Port of Boston Authority; and others.

Local and regional planning is carried on by official boards of the individual cities and towns and also by the State. Many of the cities and towns have filed master plans with the State Planning Board. The State Planning Board has concerned itself with studies not only of land, water, power, industry, transport and public works, but also with recreation and community planning.

*Economic Relations*

Boston is the commercial and cultural hub of Greater Boston. Surrounding communities fall roughly into three groups in their economic relationships to Boston and to each other: Communities whose chief purpose is to provide living-places for persons working in Boston; communities which serve that purpose and also have considerable business and industry of their own; and communities which are industrialized urban centers in their own right, interchanging workers with Boston and other communities, but depending to a considerable degree on Boston for many types of shopping, amusements and cultural activities.

*The People of Greater Boston*

*Population.* The population of Greater Boston is just under two million — 1,988,561 in 1945, according to the State census. Of these, only 766,386, or 39 percent, live in Municipal Boston. According to the 1940 U. S. census, Municipal Boston was the ninth largest city in the United States, and the Boston Metropolitan Census District was the country's fifth largest metropolitan district.

The 54 communities outside Municipal Boston vary in size from 20 with less than 5,000 people (Carlisle has only 697), to Cambridge and Somerville, each with something over 100,000 people. There are 4 with 5,000 to 10,000; 14 with 10,000 to 25,000; 9 with 25,000 to 50,000; and 5 with 50,000 to 100,000. (State Census, 1945)

While the population of the Area has increased steadily, between 1930 and 1940 there were decreases in 9 cities and towns, including the 3 largest, Boston, Cambridge and Somerville, and 4 other industrialized cities, Chelsea, Everett, Malden and Revere. The State Planning Board, in estimating population for 1955, has predicted further losses in these last 7 communities. In 1880, Boston had 54 percent of the population in the 43 municipalities now served by the Metropolitan District Commission; in 1945, only 37 per cent. Thus there appears to be a strong tendency toward decentralization of population within Greater Boston.

*National Origins.* Into the Boston and Greater Boston of revolutionary stock, has flowed a steady stream of newcomers from other lands, principally Ireland, Italy, Canada, and Russia. In 1940, Canadians formed the largest group of foreign-born persons in Greater Boston, and the second largest group in Municipal Boston. In Municipal Boston those born in Ireland were in 1940 the largest group of foreign-born.

In 1940, foreign-born white persons in Municipal Boston formed 23.5 percent of its population. This was a higher proportion than in any city of 100,000 population or over, except New York, New Bedford, Massachusetts, and Paterson, New Jersey. In Greater Boston, the proportion of foreign-born white persons was 21 percent, which may be compared with a figure of 18.5 in the metropolitan areas of Detroit and Chicago, 13 percent in metropolitan Philadelphia, and 6 percent in metropoltan St. Louis.

In 1940, Negroes formed 3.1 percent of the population in Municipal Boston and 4.4 percent in Cambridge. Chicago and Detroit had between 8 and 10 percent; Philadelphia and St. Louis, 13 percent. In Greater Boston, Negroes were only 1.8 percent of the population in 1940, as compared with 7 percent in the Chicago and Detroit metropolitan areas and nearly 11 percent in the Philadelphia and St. Louis areas.

*Religious Composition.* No recent authoritative figures are available to show the composition of the population by religious affiliation. A census in 1936 of religious membership provides figures for church membership in the 14 largest communities of the Survey Area. Of the total population of these cities and towns, 36 percent were reported as Roman Catholic; 12 percent as Protestant; and 12 percent as Jewish; less than one percent had other religious memberships; and nearly 40 percent were reported as having no religious membership. In Municipal Boston, 40 percent were reported as Catholic; 11 percent as Protestant; 15 percent as Jewish; less than one percent with other memberships; and about 33 percent with no religious membership. It may be, as has been suggested, that the religious preferences of those reporting no religious membership should be distributed among the denominations in about the same proportions as those prevailing among church members. A mid-western Catholic Bishop several years ago stated that 74 percent of Municipal Boston's population then adhered to the Catholic religion. Recent reliable estimates of Jewish population show a decrease in Municipal Boston and an increase in certain suburban communities. A more recent and more accurate count than any of the above sources represent is required before reliable figures for religious groupings can be given.

*Age Distribution.* The population by age groups in Greater Boston, as compared with other selected metropolitan areas, in 1940 was as follows:

| Age Group | Number in Greater Boston | Per cent of total population | | | | | |
|---|---|---|---|---|---|---|---|
| | | Greater Boston | Chicago | Detroit | Los Angeles | Philadelphia | St. Louis |
| Under 5 years | 125,802 | 6.6 | 6.5 | 7.7 | 6.2 | 6.5 | 6.5 |
| Under 18 years | 515,390 | 27.0 | 25.2 | 28.9 | 23.1 | 26.7 | 25.6 |
| Age 18 through 64 | 1,237,468 | 64.9 | 69.1 | 67.2 | 68.3 | 66.4 | 67.3 |
| Age 65 and over | 154,890 | 8.1 | 5.7 | 3.9 | 8.6 | 6.9 | 7.1 |

Thus it is seen that Greater Boston had a slightly larger proportion of children under age 5 than did the other metropolitan areas shown, except Detroit; and the proportion of those 65 years and over was considerably higher than in Detroit and Chicago, being exceeded only in Los Angeles.

Between 1930 and 1940, in the 31 cities and towns of Greater Boston whose population was 10,000 and over, the proportion of children under age 5 decreased from 8.3 percent to 6.6 percent. At the same time persons age 65 and over increased from 5.9 percent to 8.3 percent. From 1940 to 1945, however, the age group under 5 is estimated to have increased from 6.6 percent to 8.6 percent. Persons 65 years and over are estimated to have increased from 8.1 percent in 1940 to 9.4 percent in 1947.

*Education and Occupation.* The general educational level of a community may be measured by the median number of school years completed by its adult population. In Greater Boston in 1940, the population age 25 years and over showed a median of 9.9 school years completed, i.e., half of those 25 years and over had had 9.9 years of grade school and above, while half had had less. This was nearly one year less than in metropolitan Los Angeles, but was one to nearly two years more than in metropolitan Chicago, Detroit, Philadelphia or St. Louis. Boston's proportion of those who had had four years of high school or more was larger than in any of these areas except Los Angeles. At the same time Boston was fairly high in its percentage of people age 25 and over who had completed no school years.

When the cities and towns which make up Greater Boston are compared with each other, marked differences among them in educational makeup are revealed. For persons 25 years and over, municipal Boston's median for school years completed was 8.9; Chelsea's was 8.3; but there were ten cities and towns where the median was 12 years or more, i.e., high school completion or better.

A community's economic status is indicated by the occupations in which its workers are employed. Seven occupational groups, based on U. S. Census reporting, have been defined by the Research Bureau

of the Greater Boston Community Council. In 1940 Greater Boston, when compared with Metropolitan Chicago, Detroit, Los Angeles, Philadelphia and St. Louis, had higher proportions of professional and semi-professional workers and of proprietors, managers and officials, and a lower proportion of operatives and laborers, than any of these except Los Angeles.

Economic differences among the communities of the Greater Boston Area are evidenced by occupational figures for the individual towns and cities. For example, in 1940, in 7 of the 32 towns and cities for which figures are available, there were more professional and semi-professional workers and proprietors, managers and officials, than workers in any other occupational group. In contrast, the largest occupational group in one community was composed of those on work relief or seeking work.

Economic insecurity in a community is indicated by the proportion of the labor force which is unemployed in times of employment scarcity. In such a period, 1940, Revere had 25 percent of its labor force either seeking work or on work relief, while Wellesley had only 5 percent. Municipal Boston and 6 other communities showed 19 to 25 percent unemployed, while the other 25 communities for which figures are available showed from 5 to 16 percent.

Thus education and occupation give clear evidence of the social and economic diversity among the towns and cities of Greater Boston.

*Conditions for Living in Greater Boston*

*Physical Setting.* In natural environment Greater Boston enjoys many assets. Ocean beaches and lovely New England country-side are accessible to all the communities by public transportation. A metropolitan park system of over 11,000 acres supplements local parks, offering woods, beaches, hills, ponds and rivers with facilities for picnicking, athletic activities and quiet relaxation.

Within this pleasant setting are the wide spaces of semi-rural towns such as Carlisle, with less than 45 persons per square mile; and, by contrast, the urban density of Somerville, where over 100,000 people occupy an area of 4 square miles. Here, too, is Boston's historic North End, where the Paul Revere House and the Old North Church stand among tenements whose 19,000 residents live crowded together at a density rate of over 60,000 persons per square mile. Because much of the North End is used for commercial purposes, the actual population density on the land in use for dwellings is at the enormous rate of nearly 600,000 persons per square mile.

*Housing.* Varied, too, are the characteristics and the quality of housing. Most Bostonians live in multi-family houses: Row houses, some still fine, some converted to apartments or lodging houses or settled into decay; tenements with little outside light or air; three-story wooden flats popularly known as "three deckers"; the six low-rent public housing projects of the Boston Housing Authority; and two-family houses. There are few modern elevator apartment houses. Much of the housing is old, both in Boston and surrounding towns. Some of the oldest homes are well-preserved and still lovely after a century or more of use; many are obsolete and deteriorated. In 1940, 40 percent of the houses in Boston had been built before 1900, and 20 percent either needed major repairs or lacked private bath tub or private toilet.

Extending out from Boston along the principal transit routes, residential concentration continues in the form of apartments, row houses and tenements. Beyond these routes single family houses predominate. In the outer portions of Municipal Boston and in surrounding towns are large areas with attractive single family houses and gardens; but there are also suburban slums. As of January, 1945, the Metropolitan Housing Association reported 73,500 substandard homes located in Boston, Cambridge, Chelsea, Everett, Somerville and other municipalities. The shortage of housing in the Metropolitan Area was estimated to be 97,000 units, inclusive of substandard dwellings which should be replaced. Some new construction is now going on, and more is planned for Boston and other communities of Greater Boston, but much remains to be done.

*Social and Health Resources and Need.* The social and health resources of Greater Boston are dealt with in detail in the Survey's Divisional Reports and later in this Summary Report, so that no description here is needed.

Municipal Boston is divided into 15 Health and Welfare Areas for purposes of compiling census data and other social facts. These Areas, which conform in general to familiar divisions of Boston, are: Back Bay, Brighton, Charlestown, Dorchester North, Dorchester South, East Boston, Hyde Park, Jamaica Plain, North End, Roslindale, Roxbury, South Boston, South End, West End and West Roxbury. In order to compare Municipal Boston with the 54 other cities and towns of Greater Boston with respect

to social need, it is helpful to treat these 15 Health and Welfare Areas as separate communities. Thus 69 communities are compared.

An Index of Social Need has been constructed by the Survey staff to show the relative need for health and welfare services in these 69 communities. The Index is based on the following 12 factors indicating economic, social and health conditions in the community:[1] Infant Mortality Rate; Tuberculosis Rate for New Cases; Tuberculosis Death Rate; Median Rent; Juvenile Delinquency Rate; Massachusetts Society for the Prevention of Cruelty to Children Case Rate; Percentage of Overcrowded Households; Percentage of Households Needing Major Repairs; Old Age Assistance Rate; Aid to Dependent Children Rate; Percentage of Non-White and Foreign-Born White in Population; Percentage of Population Gained or Lost.

When the 69 communities are compared in this way, the Index shows that the areas of greatest need are: Nine Health and Welfare Areas in Municipal Boston; Cambridge; Chelsea; and the small town of Burlington. Additional areas where need is greater than average are 4 of the Health and Welfare Areas of Municipal Boston and 11 Metropolitan towns and cities. Of average need were 14 Metropolitan towns and cities and one Health and Welfare Area in Boston, Roslindale. Of less than average need were 26 Metropolitan towns and cities and one Health and Welfare Area in Boston, West Roxbury. Thus 13 of the 15 Health and Welfare Areas which make up Municipal Boston were of more than average need.

Of the 54 communities outside Boston, 14 showed above average need. These included Cambridge and Somerville, each with a population of over 100,000; 6 municipalities of 35,000 to 100,000; 3 of 5,000 to 20,000; and 2 under 5,000.

Wide differences among these 69 communities are shown by specific factors.[2] In housing, for example, a median rent of slightly over $18 per month prevailed in Boston's North End and Charlestown, as compared with $65.59 in Brookline and $65.94 in Wellesley. In Milton, only .3 percent of households were crowded; in North End, 15.8 percent.

Health figures, too, show sharp contrasts. In Bedford, for example, the infant deaths per 1,000 live births were 15; in Boston's South End, 55.7. Weston had a tuberculosis death rate of 5 per 100,000 population; South End's rate was 225.

Other factors further emphasize the wide differences among the communities. Juvenile delinquency rates range from none in Carlisle to 36.6 per 1,000 juveniles age 7 to 16 in the West End Area of Boston. Cases of the Massachusetts Society for the Prevention of Cruelty to Children showed a frequency of 15.9 to 17.8 per 1,000 households in Charlestown, South End and Roxbury; and of less than 1 per 1,000 households in Arlington, Belmont, Lincoln, Milton, Newton and Weston. In Sudbury and Medfield, no households were receiving Aid to Dependent Children; in Roxbury, 23.6 out of every 1,000 households were receiving such aid. In Winchester, 67 of every 1,000 persons age 65 and over were receiving Old Age Assistance; in South End the rate was 403.

Thus the communities of Greater Boston present not only great independence of spirit but great diversity of social composition and social need. Of course, this Survey is not the first to reveal this fact. It has seemed well, however, through presentation of a few of the more pertinent differences, to remind both ourselves and readers of this Report that, if the problems we have studied are many and hard, the path to improvement will be no less hard. But it will be even more rewarding than it is hard.

Yet today the Area is in many ways so much a unit, in which the 55 cities and towns are economically and socially interdependent, that what affects one must affect all. Of this there is growing recognition, and more and more the communities are joining in various geographical groupings for planning and action to their common advantage, whether in matters of water supply, transit, or park systems.

There is growing awareness, too, that social problems, like disease, cannot be contained within political boundaries. Slowly but increasingly, individual communities are accepting responsibilities for meeting social needs in the Area outside their own municipal borders; and for pooling their own efforts with the efforts of others to help those people who most need help. The importance of such awareness and acceptance is underscored by the fact that in some communities the services provided or available are in inverse ratio to social need. Of this changing sentiment, the Greater Boston Community Fund, and the Greater Boston Community Council are at once partial cause and grateful witness. We hope the same can later be said of the Greater Boston Community Survey.

[1]For further description of the Index see Annex I to this Report.

[2]The specific years for which these data are valid are given in General Study No. 3 of the Survey.

# EXPENDITURES FOR HEALTH AND WELFARE SERVICES, BY FIELD OF SERVICE AND SOURCE OF FUNDS, GREATER BOSTON AREA, 1946

| FIELD OF SERVICE | TOTAL EXPENDITURES 1946 | PUBLIC FUNDS | | | | PRIVATE FUNDS | | | | | | | | PER CAPITA[x] |
|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|
| | | TOTAL | LOCAL | STATE | FEDERAL | TOTAL | CONTRIBUTIONS: COMMUNITY CHEST | CONTRIBUTIONS: SECTARIAN FINANCIAL FEDERATION | CONTRIBUTIONS: OTHER SOURCES | INCOME FROM INVESTMENTS | PAYMENTS FOR SERVICE | NET PROCEEDS FROM OTHER ACTIVITIES | ALL OTHER RECEIPTS | |
| GRAND TOTAL, ALL FIELDS | $183,506,200 | $146,321,746 | $25,696,021 | $74,485,095 | $46,140,630 | $37,184,454 | $5,443,407 | $829,480 | $3,069,749 | $3,532,315 | $21,264,719 | $502,557 | $2,542,227 | $92.28 |
| I. Commonly Recognized Health and Welfare Services TOTAL | 89,843,344 | 52,678,213 | 23,585,740 | 20,611,366 | 8,481,107 | 37,165,131 | 5,443,407 | 829,480 | 3,068,563 | 3,532,315 | 21,264,719 | 484,420 | 2,542,227 | 45.18 |
| A. Economic Assistance and Social Adjustment Services* TOTAL | 40,726,669 | 33,428,958 | 11,730,239 | 13,382,613 | 8,316,106 | 7,297,711 | 1,496,533 | 324,139 | 1,426,095 | 1,343,423 | 1,191,951 | 180,209 | 1,335,361 | 20.48 |
| 1. Public assistance services | 28,672,863 | 28,672,863 | 10,452,017 | 9,989,964 | 8,230,882 | – | – | – | – | – | – | – | – | 14.42 |
| a. General assistance | 4,645,175 | 4,645,175 | 3,718,375 | 926,800 | – | – | – | – | – | – | – | – | – | 2.34 |
| b. Aid to dependent children | 4,829,532 | 4,829,532 | 2,158,502 | 1,521,325 | 1,149,705 | – | – | – | – | – | – | – | – | 2.42 |
| c. Old age assistance | 18,902,156 | 18,902,156 | 4,575,140 | 7,377,839 | 6,949,177 | – | – | – | – | – | – | – | – | 9.51 |
| d. Aid to the blind | 296,000 | 296,000 | – | 164,000 | 132,000 | – | – | – | – | – | – | – | – | .15 |
| 2. Institutional and custodial care of adults | 2,385,649 | 713,949 | 701,285 | 12,664 | – | 1,671,700 | 71,933 | – | 320,887 | 712,761 | 462,184 | 9,848 | 94,087 | 1.20 |
| a. Shelters for transients and homeless | 174,893 | 42,214 | 29,550 | 12,664 | – | 132,679 | 5,423 | – | 6,323 | 12,392 | 104,884 | – | 3,657 | .09 |
| b. Institutions for aged and dependent adults | 2,210,756 | 671,735 | 671,735 | – | – | 1,539,021 | 66,510 | – | 314,564 | 700,369 | 357,300 | 9,848 | 90,430 | 1.11 |
| 3. Family services primarily social adjustment | 2,480,376 | 615,794 | – | 615,794 | – | 1,864,582 | 708,596 | 121,951 | 565,349 | 162,208 | 118,187 | 4,998 | 183,293 | 1.25 |
| a. Family service | 1,644,154 | – | – | – | – | 1,644,154 | 651,398 | 114,121 | 519,536 | 100,030 | 79,429 | 4,998 | 174,642 | .83 |
| b. Social service to travelers | 178,312 | – | – | – | – | 178,312 | 32,240 | 7,830 | 33,630 | 62,149 | 38,264 | – | 4,199 | .09 |
| c. Medical social service* | | | | | | | | | | | | | | |
| d. Domestic relations service | 657,910 | 615,794 | – | 615,794 | – | 42,116 | 24,958 | – | 12,183 | 29 | 494 | – | 4,452 | .33 |
| 4. Specialized services for children | 5,010,044 | 3,161,933 | 576,937 | 2,583,478 | 1,518 | 1,848,111 | 456,277 | 101,409 | 306,815 | 299,378 | 361,541 | 114,102 | 208,589 | 2.52 |
| a. Protective and foster care | 2,938,930 | 1,632,980 | 499,085 | 1,133,895 | – | 1,305,950 | 312,734 | 83,955 | 228,093 | 266,457 | 253,066 | 54,140 | 107,505 | 1.48 |
| b. Day nurseries# | 99,230 | 1,518 | – | – | 1,518 | 97,712 | 32,984 | 2,295 | 24,914 | 6,244 | 20,004 | 2,082 | 9,189 | .05 |
| c. Probation services for children | 118,599 | 94,150 | 27,940 | 66,210 | – | 24,449 | 3,762 | 7,492 | 468 | 2,854 | 9,100 | – | 773 | .06 |
| d. Institutions for delinquent children | 1,853,285 | 1,433,285 | 49,912 | 1,383,373 | – | 420,000 | 106,797 | 7,667 | 53,340 | 23,823 | 79,371 | 57,880 | 91,122 | .93 |
| 5. Specialized services for the handicapped | 1,218,627 | 264,419 | – | 180,713 | 83,706 | 954,208 | 80,524 | 1,922 | 18,277 | 5,297 | 21,509 | 41,049 | 785,630 | .61 |
| 6. Maternity home care | 304,326 | – | – | – | – | 304,326 | 39,568 | – | 84,749 | 18,333 | 148,892 | 4,269 | 8,515 | .15 |
| 7. Other£ | 654,784 | – | – | – | – | 654,784 | 139,635 | 98,857 | 130,018 | 145,446 | 79,638 | 5,943 | 55,247 | .33 |
| B. Health Services* TOTAL | 41,992,549 | 17,556,513 | 10,164,741 | 7,228,753 | 163,019 | 24,436,036 | 1,604,425 | 307,089 | 844,217 | 1,858,031 | 18,602,176 | 179,823 | 1,040,275 | 21.12 |
| 1. Hospital care● | 38,055,186 | 15,515,335 | 8,219,394 | 7,133,878 | 162,063 | 22,539,851 | 1,047,091 | 307,089 | 427,714 | 1,644,177 | 18,046,848 | 100,960 | 965,972 | 19.14 |
| a. General hospital service | 27,005,473 | 6,136,228 | 5,323,562 | 650,603 | 162,063 | 20,869,245 | 1,007,138 | 250,061 | 345,904 | 1,549,646 | 16,901,696 | 49,434 | 765,366 | 13.59 |
| b. Chronic disease and tuberculosis hospital service | 4,700,980 | 3,708,486 | 2,892,832 | 815,654 | – | 992,494 | 39,953 | 57,028 | 77,259 | 53,008 | 513,114 | 51,526 | 200,606 | 2.36 |
| c. Mental hospital service | 6,348,733 | 5,670,621 | 3,000 | 5,667,621 | – | 678,112 | – | – | 4,551 | 41,523 | 632,038 | – | – | 3.19 |
| d. Hospital admitting and certifying bureaus | NOS | | | | | | | | | | | | | |
| 2. Clinic care, other than in hospitals | 1,241,493 | 541,321 | 446,185 | 94,875 | 261 | 700,172 | 172,784 | – | 197,889 | 50,689 | 208,235 | 42,929 | 27,646 | .62 |
| a. Clinic service | 697,592 | 167,813 | 122,527 | 45,286 | – | 529,779 | 99,385 | – | 158,986 | 22,214 | 193,654 | 42,929 | 12,611 | .35 |
| b. Mental hygiene clinics | 215,331 | 49,850 | – | 49,589 | 261 | 165,481 | 73,399 | – | 38,903 | 28,475 | 9,669 | – | 15,035 | .11 |
| c. School hygiene medical service | 328,570 | 323,658 | 323,658 | – | – | 4,912 | – | – | – | – | 4,912 | – | – | .16 |
| 3. Nursing services–Public health and school hygiene nursing | 1,367,656 | 718,425 | 717,730 | – | 695 | 649,231 | 259,826 | – | 41,474 | 81,375 | 244,836 | 8,099 | 13,621 | .69 |
| 4. Other | 1,328,214 | 781,432 | 781,432 | – | – | 546,782 | 124,724 | – | 177,140 | 81,790 | 102,257 | 27,835 | 33,036 | .67 |
| C. Recreation, Informal Education and Groupwork Services TOTAL | 6,294,805 | 1,692,660 | 1,690,678 | – | 1,982 | 4,602,145 | 1,590,457 | 155,582 | 786,463 | 327,104 | 1,464,080 | 124,349 | 154,110 | 3.16 |
| 1. Community-wide building centered programs | 1,480,074 | – | – | – | – | 1,480,074 | 495,011 | 32,369 | 149,695 | 151,056 | 582,276 | 55,725 | 13,942 | .74 |
| 2. Neighborhood building centered programs | 1,456,009 | 107,982 | 106,000 | – | 1,982 | 1,348,027 | 718,920 | 86,437 | 250,632 | 100,340 | 108,060 | 34,835 | 48,803 | .73 |
| 3. Neighborhood non-building centered programs | 311,260 | – | – | – | – | 311,260 | 230,921 | 1,242 | 27,699 | 8,086 | 27,095 | 8,124 | 8,093 | .16 |
| 4. Playgrounds and general recreation programs | 1,709,460 | 1,584,678 | 1,584,678 | – | – | 124,782 | 4,642 | – | 169 | – | 119,812 | – | 159 | .86 |
| 5. Established summer camps | 1,023,450 | – | – | – | – | 1,023,450 | 123,981 | 35,534 | 191,917 | 40,539 | 536,718 | 20,141 | 74,620 | .51 |
| 6. Other | 314,552 | – | – | – | – | 314,552 | 16,982 | – | 166,351 | 27,083 | 90,119 | 5,524 | 8,493 | .16 |
| D. Planning, Financing and Common Services TOTAL | 829,321 | 82 | 82 | – | – | 829,239 | 751,992 | 42,670 | 11,788 | 3,757 | 6,512 | 39 | 12,481 | .42 |
| 1. Planning–Community welfare council | 156,515 | – | – | – | – | 156,515 | 151,657 | – | 3,006 | 30 | 748 | – | 1,074 | .08 |
| 2. Financing | 491,851 | – | – | – | – | 491,851 | 452,560 | 24,363 | 65 | 3,551 | – | – | 11,312 | .25 |
| a. Community Chest | 466,851 | – | – | – | – | 466,851 | 452,560 | – | 65 | 2,914 | – | – | 11,312 | .24 |
| b. Sectarian federations | 25,000 | – | – | – | – | 25,000 | – | 24,363 | – | 637 | – | – | – | .01 |
| 3. Common services | 180,955 | 82 | 82 | – | – | 180,873 | 147,775 | 18,307 | 8,717 | 176 | 5,764 | 39 | 95 | .09 |
| a. Social service exchange | 30,580 | – | – | – | – | 30,580 | 29,734 | – | – | – | 846 | – | – | .01 |
| b. Information and referral centers | 94,668 | 82 | 82 | – | – | 94,586 | 92,084 | – | 1,924 | 19 | 559 | – | – | .05 |
| c. Other | 55,707 | – | – | – | – | 55,707 | 25,957 | 18,307 | 6,793 | 157 | 4,359 | 39 | 95 | .03 |
| II. Other Health and Welfare Services TOTAL | 93,662,856 | 93,643,533 | 2,110,281 | 53,873,729 | 37,659,523 | 19,323 | – | – | 1,186 | – | – | 18,137 | – | 47.10 |
| A. Correctional Work TOTAL | 2,470,958 | 2,451,635 | 976,682 | 1,474,953 | – | 19,323 | – | – | 1,186 | – | – | 18,137 | – | 1.24 |
| B. Metropolitan District Commission | 1,133,599 | 1,133,599 | 1,133,599 | – | – | – | – | – | – | – | – | – | – | .57 |
| C. Veterans Administration | 22,773,350 | 22,773,350 | – | – | 22,773,350 | – | – | – | – | – | – | – | – | 11.45 |
| D. Division of Unemployment Security | 53,504,949 | 53,504,949 | – | 52,398,776 | 1,106,173 | – | – | – | – | – | – | – | – | 26.91 |
| E. Old-Age and Survivors Insurance | 13,780,000 | 13,780,000 | – | – | 13,780,000 | – | – | – | – | – | – | – | – | 6.93 |

Note 1 – In some instances where actual figures could not be obtained, estimates were made on the basis of factors bearing a direct relation to the expenditures. These estimates do not alter the proportions or any conclusions to be drawn from the table.

Note 2 – Section I, *Commonly Recognized Health and Welfare Services*, corresponds to the 1946 Expenditure Study sponsored by Community Chests and Councils, Inc.

NOS – No organized service.
* Medical social service expenditures included in *Health Services, Hospital care*, Items B-1. a to c.
# Settlement nursery school expenditures included under Item C-2.
£ School lunch programs not included.
● Medical social service and out-patient care included.
[x] Based on 1945 State census population of 1,988,561.

Greater Boston Community Survey

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## II. Expenditures for Health and Welfare Services in Greater Boston

Ninety million dollars is being spent every year by some 800 tax-supported and voluntary agencies for commonly recognized health and welfare services in Greater Boston. In 1946, the latest year for which full details are available, this annual expenditure worked out to $45.18 per capita for the 2,000,000 people of Greater Boston.

Where does this money go? Where does it come from? Does Greater Boston spend enough? Or too much? Or not enough in some places and too much in others? Does the money come in the right proportions from the right sources? How does Greater Boston's showing in all these respects compare with that of other large urban areas? The answers to many of these questions are, of course, matters of local judgment. A survey can offer points of view that should be useful in forming that judgment.

### *How Much Is Spent*

On a straight comparison with other communities, Greater Boston can be proud of its showing in total expenditures. Twenty-nine urban areas in the United States for which figures have been compiled showed in 1946 an average per capita expenditure of only $32.48, as is shown in the following table:

Per Capita Expenditures for Public and Private Health and Welfare Services in Greater Boston; in a Group of 29 Other Urban Areas in the U.S.A.; and in 6 Selected Large Urban Areas, 1946

| Urban Area | All Services | Economic Assistance and Social Adjustment Services | Health Services | Recreation, Informal Education and Group Work Services | Planning, Financing and Common Services |
|---|---|---|---|---|---|
| Boston | $45.18 | $20.48 | $21.12 | $3.16 | $ .42 |
| 29 Other Urban Areas | 32.48 | 14.80 | 14.86 | 2.42 | .40 |
| Baltimore | 32.52 | 11.27 | 17.12 | 3.77 | .36 |
| Buffalo | 28.75 | 11.20 | 15.01 | 2.21 | .33 |
| Cleveland | 31.65 | 11.69 | 17.09 | 2.31 | .56 |
| Los Angeles | 34.07 | 20.02 | 11.72 | 1.90 | .43 |
| Milwaukee | 30.41 | 11.75 | 14.95 | 3.51 | .20 |
| St. Louis | 31.58 | 13.24 | 15.90 | 1.93 | .51 |

Some of the urban areas included in the composite of the 29 were much smaller (as well as probably poorer) than Greater Boston. But Greater Boston's per capita of $45.18 tops by a wide margin the highest per capita figure for any of the six large urban areas shown above ($34.07 for Los Angeles). Of the entire 29 areas, only Hartford and Seattle had an over-all per capita expenditure exceeding that of Greater Boston. Whatever weaknesses may be revealed in Greater Boston's social and health practices, *underexpenditure* for its commonly recognized health and welfare services is not one.

Looking at the figures shown above for each field of service, we see that Greater Boston's per capita expenditure also exceeds the average for all 29 areas in every field. However, when we compare Greater Boston's per capita expenditure in these fields with that of the other six large areas, we find: Greater Boston leads in *health services* (which includes hospitals) and in *economic and social adjustment services* (i.e. public welfare, family and child care, and related case work services); is in third place in *recreation, informal education and group work services;* is in fourth place for per capita expenditure for *planning, financing and other common services.* Boston's eminence as a health and medical center is attested here. In the other fields, the Survey staff found conditions which the expenditure figures may help to explain. We think the changes we recommend will go far toward improving the services in these fields, and in the health field as well, without calling for the expenditure of more money over-all.

### *Where the Money Goes*

Greater Boston divides its health and welfare expenditures among the four major fields of service in almost the same proportions as do the 29 other urban areas; spending a slightly higher percentage on health services and a slightly lower percentage on each of the other three fields.

Percentage Distribution of Expenditures for Public and Private Health and Welfare Services in Greater Boston and 29 Other Urban Areas, 1946

| | Percent of Total | |
|---|---|---|
| | Greater Boston | 29 Other Urban Areas |
| Total | 100.0 | 100.0 |
| Economic Assistance and Social Adjustment Services | 45.3 | 45.6 |
| Health Services | 46.7 | 45.7 |
| Recreation, Informal Education and Group Work Services | 7.0 | 7.5 |
| Planning, Financing and Common Services | .9 | 1.2 |

*Where the Money Comes From*

Over half the money annually spent for the health and welfare services in Greater Boston (58.6%), as in the 29 other urban areas (55%), comes from tax funds.

| | | Percent | |
|---|---|---|---|
| | | Greater Boston | 29 Other Urban Areas |
| All Fields: Total | All sources | 100.0 | 100.0 |
| | Private | 41.4 | 45.0 |
| | Public | 58.6 | 55.0 |
| | Local | 26.3 | 21.9 |
| | State | 22.9 | 21.3 |
| | Federal | 9.4 | 11.8 |
| Economic Assistance and Social Adjustment Services: Total | All sources | 100.0 | 100.0 |
| | Private | 17.9 | 21.5 |
| | Public | 82.1 | 78.5 |
| | Local | 28.8 | 21.2 |
| | State | 32.9 | 33.2 |
| | Federal | 20.4 | 24.1 |
| Health Services: Total | All sources | 100.0 | 100.0 |
| | Private | 58.2 | 62.9 |
| | Public | 41.8 | 37.1 |
| | Local | 24.2 | 22.1 |
| | State | 17.2 | 13.4 |
| | Federal | .4 | 1.6 |
| Recreation and Group Work Services: Total | All sources | 100.0 | 100.0 |
| | Private | 73.1 | 72.2 |
| | Public | 26.9 | 27.8 |
| | Local | 26.9 | 27.1 |
| | State | 0 | .2 |
| | Federal | 0 | .5 |
| Planning, Financing and Common Services: Total | All sources | 100.0 | 100.0 |
| | Private | 100.0 | 87.5 |
| | Public | –[a] | 12.5 |
| | Local | –[a] | 9.2 |
| | State | 0 | 2.1 |
| | Federal | 0 | 1.2 |

[a] Less than .05

This table shows that Greater Boston received a smaller percentage from federal sources than did the other areas — 9.4% compared with their 11.8% average. Translating this difference in percentages into dollars spent by Greater Boston, comes to over $2,000,000 a year. This is a large sum of money for Boston *not* to get.

Why are the federal funds received by Greater Boston relatively less in amount than for other urban areas? Most of the federal funds go into public assistance. In Greater Boston, only 28.7 percent of the funds spent for public assistance came from the federal treasury, while 34.5 percent of such expenditures by the 29 other urban areas came from that source. Among the six largest of these urban areas, five secured

from federal funds over 30 percent of their public assistance outlay, and one of the five (St. Louis) received a little more than 42 percent.

A partial explanation of this striking disparity between Greater Boston and the other communities may be that aged people who should receive Old Age Assistance, and families that should receive Aid to Dependent Children, are continued on General Relief. Furthermore, under Massachusetts law non-citizens are not entitled to OAA; if they receive public assistance at all, they must receive only General Relief. No federal funds help to meet the costs of General Relief, whereas such funds contribute a great deal of the cost of OAA and ADC. Federal funds will not help pay the costs of hospital care for OAA and ADC clients unless the public welfare agency makes its payments for such care direct to the client; and in Municipal Boston appropriations are made directly to Boston City Hospital which cover ADC clients.

Similarly, for health services Greater Boston derived less federal support than the other communities, receiving from federal funds .4 percent of expenditures as compared with 1.6 percent for the other 29 urban areas. All six of the large urban areas received a higher percentage of federal funds for health than Greater Boston.

Further evidence of how other urban areas are using federal support for local services is shown in the per capita figures. Of Los Angeles' per capita health and welfare expenditures, $5.65 was from federal sources; Seattle showed $8.15 per capita from federal sources; but Greater Boston had only $4.27. The communities in the eastern part of the country appear to have depended much more on their own resources than have many communities farther west, where a considerable number received more federal funds per capita for their health and welfare services than did Greater Boston.

These facts raise the important question as to whether Greater Boston is taking full advantage of support from federal sources.

*Payments for Service.* Payments for service by those who are benefited provide the agencies' largest single source of private support. In Greater Boston, such payments came to 24 percent of all that was spent; but payments accounted for 30 percent of the money spent by the 29 other urban areas.

Expenditures for Public and Private Health and Welfare Services in Greater Boston by Source of Funds, and Comparison of Percentages Expended from Each Source in Greater Boston and in 29 Other Urban Areas, 1946

| | Percent of Total | |
|---|---|---|
| | Greater Boston | 29 Other Urban Areas |
| Total, Community Recognized Services | 100.0 | 100.0 |
| Public Funds Total | 58.6 | 55.0 |
| Local | 26.3 | 21.9 |
| State | 22.9 | 21.3 |
| Federal | 9.4 | 11.8 |
| Private Funds Total | 41.4 | 45.0 |
| Contributions, Community Chest | 6.1 | 6.1 |
| Contributions, Sectarian Financial Federation | .9 | .5 |
| Contributions, Other Sources | 3.4 | 3.7 |
| Income from Investments | 3.9 | 1.6 |
| Payments for Services | 23.7 | 29.7 |
| Net Proceeds from Other Activities | .5 | 1.0 |
| All Other Receipts | 2.8 | 2.4 |

This difference of 6% between Greater Boston and the composite average of the 29 other urban areas amounts in dollars to $5,400,000. The above figures apply to the year 1946, when many Greater Boston agencies — notably hospitals — were in serious financial difficulties, at least a part of which were caused by low rates charged to recipients of their service. The story on this score should be more favorable now, for in the last two years a considerable number of agencies, again notably hospitals, have raised their rates to private individuals and are being paid at a higher rate by certain public departments.

These figures are even more striking when we look at the payments for service as a percentage of expenditures, field by field:

Payments for Service as a Percentage of Expenditures by Fields of Service in Greater Boston, in 29 Other Urban Areas and in 6 Selected Large Urban Areas, 1946

| Field | Greater Boston | 29 Other Urban Areas | Selected Large Urban Areas: Balti-more | Buffalo | Cleve-land | Los Angeles | Mil-waukee | St. Louis |
|---|---|---|---|---|---|---|---|---|
| Economic Assistance and Social Adjustment | 2.9 | 5.6 | 3.3 | 5.4 | 3.8 | 5.0 | 5.0 | 8.0 |
| Health | 44.3 | 55.0 | 54.3 | 51.5 | 55.9 | 55.1 | 51.9 | 45.7 |
| Recreation | 23.3 | 25.9 | 19.9 | 18.4 | 31.5 | 19.2 | 32.7 | 26.5 |
| Planning and Financing | .8 | .7 | — | — | 1.8 | 1.0 | — | — |
| All Fields | 23.7 | 29.7 | 32.0 | 30.4 | 34.0 | 22.9 | 31.2 | 28.0 |

Of the total spent on health services (which include hospitals) by the 29 other areas, 55 percent was received back in payments for services; in Greater Boston, only 44 percent. Payments for recreation services returned to the other communities 26 percent of expenditures in that field; in Greater Boston, 23 percent. Payments for services of economic assistance and help with personal problems in the other communities covered nearly 6 percent of expenditures; but in Greater Boston they amounted to only 3 percent.

Breaking down 1946 payments for health services, we find that Greater Boston hospitals were paid by patients only 47 percent of costs as compared with 62 percent paid in the 29 other areas. Applied to hospital expenditures in Greater Boston, an additional 15 percent of return from payment would represent several million dollars.

In the field of recreation, Greater Boston's lag in payments of somewhat less than 3 percent of outlay may seem insignificant, but when translated into money it amounts to $165,000. Two of the largest urban areas reported payments in this field covering over 30 percent of expenditures. If Greater Boston could achieve such a return, the recreation agencies would gain back an added $485,000.

Agencies in Greater Boston giving specialized services to children received payments for service amounting to 7 percent of their expenditures; but payments met 15 percent of such expenditures for the 29 areas as a whole. Looking at the figures for payments in relation to what *voluntary* agencies alone spend for children's services, we find that in Greater Boston they amount to about one fifth of such expenditures; in the 29 other communities, to over one third.

In 1946 Greater Boston agencies were not requiring recipients of service to pay as large a share of the cost of such service as were other communities. Whereas the situation in 1949 may be different, it clearly behooves agencies in this Area to look closely at their rate schedules.

*Net Proceeds from Activities.* Social and health agencies are non-profit making. Yet some of them have activities receipts which help to finance services. Dormitories and restaurants operated by Y.M. and Y.W.C.A.'s are examples. Greater Boston agencies showed .5 percent of total expenditures earned in this way; the other 29 areas showed 1 percent — not much more, as measured in percentages; yet, if Greater Boston agencies had earned the same proportion, they would have had additional receipts from this source amounting to over $400,000. Can Greater Boston agencies improve the returns from their income-producing activities?

*Fund Contributions.* Community Chests are the second largest source of private support of social and health agencies. In 1946 Greater Boston agencies received from the Community Fund a little over 6 percent of all funds spent, which is about the same proportion as was received from the group of 29 urban areas from their Chests. Greater Boston, however, differs strikingly from other communities in the way it distributes the Community Fund dollar among the fields of service:

Percentage Distribution of Chest Funds by General Fields of Service, in Greater Boston, in 29 Other Urban Areas and in 6 Selected Urban Areas, 1946

| | Greater Boston | 29 Other Urban Areas | Selected Urban Areas: Balti-more | Buffalo | Cleve-land | Los Angeles | Mil-waukee | St. Louis |
|---|---|---|---|---|---|---|---|---|
| Economic Assistance and Social Adjustment | 27.5 | 38.4 | 36.7 | 36.2 | 46.9 | 30.8 | 45.0 | 43.7 |
| Health Services | 29.5 | 16.1 | 25.7 | 8.8 | 17.5 | 19.2 | 21.0 | 17.9 |
| Recreation and Group Work Services | 29.2 | 30.9 | 25.9 | 42.8 | 21.8 | 29.3 | 22.3 | 23.0 |
| Planning, Financing and Common Services | 13.8 | 14.6 | 11.7 | 12.2 | 13.8 | 20.7 | 11.7 | 15.4 |

Unlike any one of the other 29 communities, Greater Boston puts more of the Fund dollar into health and hospital services than into either services of economic assistance and social adjustment or recreation and group work services. Of every Fund dollar spent by the other 29 urban areas, 38 cents went for services of economic assistance and other help to families, children, the aged and handicapped, while 16 cents went to health and hospital services. In Greater Boston, however, 29 cents went to health and hospital services, and only 27 cents to these other services. Hospitals receive the great share of Greater Boston's more generous distribution to the health field. From the Fund dollar of the 29 other areas, not quite 7 cents goes to hospitals. In the six largest of the areas, the Fund dollar yields from 3 cents to 17 cents for hospitals. But Greater Boston gives the hospitals over 19 cents of every Fund dollar. (All figures as of 1946.)

Greater Boston hospitals receive from patients a smaller percentage of their costs than do hospitals in the 29 other areas we have been considering. Here is one reason why the Fund gives to hospitals a larger share of its dollar than Chests give to hospitals in the other areas; inevitably leaving less of the Fund dollar for the remaining fields of service.

After distribution to the health field and to the field of economic assistance and social adjustment there remains 43 cents of the Fund dollar as compared with 45.5 cents remaining from the Chest dollar of the other urban areas. This means, of course, that Greater Boston has a correspondingly smaller part of the Fund dollar for the support of recreation and group work services and for planning and financing services.

Is this unique distribution of Greater Boston's Fund dollar peculiarly adapted to Boston's particular needs?

The foregoing does not, of course, imply that the adequacy of any community's social and health services can be judged merely by ascertaining how much money is spent on them, or even by the kind of comparisons we have attempted. The most that such a comparative analysis can do is to raise questions. We have pointed to a few of the questions which these tables raise. As revealed in our Division Reports, and in the Summary of those reports that follows, specialists on the Survey staff pursued the leads thus offered, and found those leads of substantial help in making their own judgments on the structure, policy, and practices of the agencies studied.

## TOTAL EXPENDITURES OF AND COMMUNITY FUND PAYMENTS FOR VOLUNTARY AGENCIES INCLUDED IN THE DIVISIONAL REPORTS, 1947

Presented below are total expenditures for 1947 for the major voluntary agencies in each Divisional Report of the Survey and Community Fund payments to agencies which are members of the Greater Boston Community Fund. In a few instances, for comparative purposes, expenditures for public agencies and certain proprietary hospitals have been given as well.

| HEALTH DIVISION | 1947 Expenditures | Fund Payment |
|---|---|---|
| American Cancer Society | $ 364,673(a) | $ — |
| American National Red Cross, Local Chapters | — (b) | — |
| Arlington Visiting Nurse Association | 14,393 | 6,806 |
| Bay State Society (State-wide Program) | 83,793 | — |
| Belmont Community Nursing Association | 6,082 | 2,830 |
| Belmont Nutrition Council | 1,312 | 690 |
| Boston Health League | 5,479 | — (c) |
| Boston T. B. Association | 115,616 | — |
| Braintree Visiting Nurse Association | 18,710 | 7,640 |
| Brookline Anti-T. B. Society | 1,370 | — |
| Brookline Friendly Society Total Program | 53,096 | 22,203 |
| Nursing Service and Health Center | (23,864) | — |
| Cambridge T. B. and Health Association | 23,023 | 359 |
| Cambridge Visiting Nurse Association | 28,041 | 13,000 |
| Canton Nursing Association | 4,109 | 2,373 |
| Chelsea Visiting Nurse Association | 7,981 | — |
| Community Workshops | 99,265 | 31,991 |
| Concord Visiting Nurse Association | 5,650 | — |
| Dedham Visiting Nurse Association | 20,526 | 10,998 |
| Epilepsy League of New England | 3,806 | — |
| Everett Visiting Nurse Association | 9,196 | 5,200 |
| Forsyth Dental Infirmary | 191,236 | — |
| Greater Boston Nursing Council | 5,392 | — (c) |
| Hingham Visiting Nurse and Community Service | 7,394 | 1,380 |
| Household Nursing Association | 45,902 | 10,072 |
| Hospital Council of Boston | 5,814 | — (c) |
| Lexington Visiting Nurse Association | 10,088 | 7,861 |
| Malden Children's Health Campaign | 3,431 | 2,450 |
| Malden Industrial Aid, Total Program | 13,115 | 3,000 |
| Malden T. B. and Health Association | 9,433(d) | — |
| Massachusetts Central Health Council | 285(e) | — |
| Massachusetts Society for Mental Hygiene | 18,713 | 12,000 |
| Massachusetts Society for Social Hygiene | 25,346 | 10,005 |
| Massachusetts T. B. League, Inc. | 121,876(d) | — |
| Massachusetts Public Health Association | N.R. | — |
| Medford Visiting Nurse Association | 11,951 | 4,524 |
| Middlesex Health Association | 50,636(d) | — |
| Millis Visiting Nurse Association | N.R. | — |
| Natick Visiting Nurse Association | 4,963 | 2,422 |
| National Foundation for Infantile Paralysis | N.R. | — |
| Needham Dental Clinic | 2,387 | 2,104 |
| Needham Visiting Nurse Association | 6,360 | 4,272 |
| New England Heart Association | 3,357 | — |
| Newton District Nursing Association | 35,423 | 19,682 |
| Newton Nutrition Center | 6,089 | 1,750 |
| Newton T. B. and Health Association | 11,998(d) | — |
| Norfolk County Health Association | 55,205(d) | — |
| Norwell Visiting Nurse Association | 3,660 | — |
| Norwood Visiting Nurse Association | 3,389 | — |
| Plymouth County Health Association | 42,143(d) | — |
| Reading Visiting Nurse Association | 5,691 | 1,998 |
| Revere Visiting Nurse Association | 6,797 | — |
| Scituate Public Health Nursing Service | 907(e) | — |
| Social Service League of Cohasset, Total Program | 6,639 | 3,943 |
| Stoneham Visiting Nurse Association | 3,795 | 933 |
| Sudbury Public Health Nursing Association | 2,679 | 1,447 |

| HEALTH DIVISION, Concluded | 1947 Expenditures | Fund Payment |
|---|---|---|
| Visiting Nurse Association of Boston | 339,786 | 134,900 |
| V. N. A. of Dover, Medfield and Norfolk | 4,625 | 550 |
| Visiting Nurse Association of Somerville | 11,629 | 1,751 |
| Wakefield Visiting Nurse Association | 5,346 | 3,200 |
| Walpole Visiting Nurse Association | 6,021 | — |
| Waltham District Nursing Association | 31,314 | 13,481(f) |
| Watertown District Nursing Association | 12,308 | 5,497 |
| Wellesley Friendly Aid, Total Program | 28,550 | 19,133 |
| Nursing Service | (15,485) | — |
| Westwood Community Health Association | 4,895 | 2,200 |
| Weymouth Visiting Nurse Association | 9,578 | 3,473 |
| Winchester District Nursing Association | 9,493 | 2,824 |
| Winthrop Visiting Nurse Association | 4,470 | — |
| Woburn Visiting Nurse Association | 5,262 | 2,805 |

(a)For fiscal year ended August 31, 1947.
(b)Expenditures for health program and nursing service not available.
(c)Fund payment for Boston Health League, Greater Boston Nursing Council and Hospital Council of Boston — $17,500.
(d)For fiscal year ended March 31, 1948.
(e)For 1946.
(f)From Waltham Community Chest.
N.R. No report.

| HOSPITAL DIVISION | 1947 Expenditures | Fund Payment |
|---|---|---|
| Allerton Hospital | $ 256,200 | — |
| Audubon Hospital | N.R. | — |
| Bay State Hospital | 66,225 | — |
| Bellevue Hospital | N.R. | — |
| Beth Israel Hospital | 1,335,466 | 303,300(a) |
| Booth Memorial Hospital | — (b) | — |
| Boston City Hospital | 6,029,856(c) | — |
| Boston Dispensary | 453,557 | 113,391 |
| Boston Evening Clinic and Hospital | 49,134 | — |
| Boston Home for Incurables | 93,871 | — |
| Boston Floating Hospital | 201,171 | 24,835 |
| Boston Lying-In Hospital | 1,018,755 | 14,250 |
| Brooks Hospital | 141,925 | — |
| Cambridge City Hospital | 926,496 | — |
| Carney Hospital | 774,011 | 4,583 |
| Central Hospital | N.R. | — |
| Charles Choate Memorial Hospital | 186,598 | 6,000 |
| Chelsea Memorial Hospital | 287,038 | — |
| Chester Hospital | N.R. | — |
| Children's Hospital | 1,529,981 | 94,150 |
| Cohasset Hospital | N.R. | — |
| Convalescent Home for Children | 120,186 | 39,150 |
| Emerson Hospital in Concord | 191,936 | — |
| Faulkner Hospital | 673,772 | — |
| Florence Crittenton League of Compassion (Total) | 88,790 | 24,653 |
| Executive Office | (12,661) | — |
| Maternity Home | (63,860) | — |
| Welcome House | (12,269) | — |
| Free Hospital for Women | 502,319 | 14,650 |
| Glover Memorial Hospital | 81,578 | — |
| Glynn Hospital | N.R. | — |
| Hahnemann Hospital | 72,486 | — |
| Harley Hospital | N.R. | — |
| Hastings House | 48,660 | 16,918 |
| Holy Ghost Hospital | 334,379(d) | — |
| House of the Good Samaritan | 115,078 | 20,911 |
| Hull Hospital | N.R. | — |

| HOSPITAL DIVISION, Concluded | 1947 Expenditures | Fund Payment |
|---|---|---|
| Infants' Hospital | 218,469 | 25,991 |
| Jamaica Plain Dispensary | N.R. | — |
| Jewish Memorial Hospital | 161,400 | 67,000(a) |
| Joseph H. Pratt Diagnostic Hospital | 248,400(e) | — |
| Kenmore Hospital | N.R. | — |
| Lawrence Memorial Hospital | 203,356 | — |
| Leonard Morse Hospital | 210,593 | 6,500 |
| Long Island Hospital | 805,994 | — |
| Longwood Hospital | N.R. | — |
| Malden Hospital, Inc. | 873,820 | 27,500 |
| Massachusetts Eye and Ear Infirmary | 845,727 | 34,300 |
| Massachusetts General Hospital | 5,345,954 | 227,700 |
| Massachusetts Lying-In and General Hospital | N.R. | — |
| Massachusetts Memorial Hospitals | 1,588,532 | 134,550 |
| Massachusetts Osteopathic Hospital | 235,738 | — |
| Massachusetts Women's Hospital | 237,345 | 8,000 |
| Maverick Dispensary | 27,545 | 11,050 |
| Medical Mission Dispensary | N.R. | — |
| Melrose Hospital Association | 439,068 | — |
| Milton Hospital and Convalescent Home | 60,688 | — |
| Mount Auburn Hospital | 1,142,687 | 8,625 |
| New England Baptist Hospital | 1,107,779 | — |
| New England Deaconess Hospital | 1,629,387 | 19,700 |
| New England Hospital for Women and Children | 709,206 | 67,850 |
| New England Peabody Home for Crippled Children | 209,032 | — |
| New England Sanatorium and Hospital | 862,538 | — |
| Newton-Wellesley Hospital | 1,079,777 | 82,583 |
| Norwood Hospital | 376,670 | — |
| Otis Hospital | 507,326 | — |
| Peter Bent Brigham Hospital | 1,371,187 | 163,325 |
| Quincy City Hospital | 677,580(f) | — |
| Revere Memorial Hospital | N.R. | — |
| Robert Breck Brigham Hospital | 318,389 | 40,000 |
| St. Elizabeth's Hospital | 912,743 | 56,000 |
| St. Margaret's Hospital and St. Mary's Infant Asylum | 514,381(g) | — |
| Sancta Maria Hospital | — (h) | — |
| Somerville Hospital | 298,886 | — |
| South Shore Hospital | 453,652 | 31,000 |
| Sunnyside Hospital | N.R. | — |
| Symmes Arlington Hospital | 57,649(e) | — |
| Waltham Hospital | 611,674 | 18,567(i) |
| Washingtonian Hospital | 99,707 | 5,000 |
| Whidden Memorial Hospital | 333,743 | 6,500 |
| Winchester Hospital | 307,315 | 7,500 |
| Winthrop Community Hospital | 165,738(f) | — |
| Wolfson Nose and Throat Hospital | N.R. | — |
| Tewksbury State Hospital | 1,584,947 | — |

(a)From Associated Jewish Philanthropies.
(b)Reorganized in 1947, no figures available.
(c)Exclusive of Sanatorium Division.
(d)For 1946.
(e)Expenditures for payroll only.
(f)For 9 months.
(g)For fiscal year ending September 30, 1948.
(h)Not in operation in 1947.
(i)From Waltham Community Chest.
N.R. No Report.

VOLUNTARY CASEWORK DIVISION

| *Family Casework Agencies* (See Table 1, p. 75) *Other Family Casework and Multi-Service Agencies* | 1947 Expenditures | Fund Payment |
|---|---|---|
| American Red Cross, Home Service Dept. | $ 517,403(a) | $ — (b) |
| International Institute of Boston (Total, all services) | 36,762 | 31,041 |
| Jewish Family and Children's Service | 102,443 | 80,643(c) |
| Morgan Memorial Coop. Industries, Family Service and Relief Bureau | 11,727 | 10,000 |

(a)Total expenditures, 1946, for 37 Chapters, including estimates for certain Chapters.
(b)Not member of Community Fund.
(c)From Associated Jewish Philanthropies.

VOLUNTARY CASEWORK DIVISION, Cont'd

| *Child Care Services* | 1947 Expenditures | Fund Payment |
|---|---|---|
| Avon Home | $ 36,372 | $ 13,200 |
| Boston Children's Friend Society | 73,931 | 24,621 |
| Children's Aid Association | 289,538 | 114,852 |
| Children's Mission to Children | 108,051 | 5,321 |
| Church Home Society | 97,820 | 40,721 |
| Citizenship Training Department | 17,300 est. | — |
| Florence Crittenton League of Compassion (Total) | 88,790 | 24,653 |
| Executive Office | (12,661) | — |
| Maternity Home | (63,860) | — |
| Welcome House | (12,269) | — |
| Hastings House | 48,660 | — |
| New England Home for Little Wanderers | 207,578 | 60,480 |
| St. Mary's Infant Asylum | 156,583(a) | — (b) |
| Salvation Army Home | 66,101(a) | — |
| Massachusetts S. P. C. C. | | |
| Boston Office Total | 155,241 | 80,983 |
| South Middlesex District | 6,232 | 1,561 |
| South Norfolk District | 5,858 | 1,918 |
| South Shore District | 6,464 | 2,145 |

(a)For 1946.
(b)Not member of Community Fund, but receives approximately $30,000 from Fund through Boston, Cambridge and Somerville Catholic Charitable Bureaus.

| *Child Guidance Clinics and Other Agencies* | 1947 Expenditures | Fund Payment |
|---|---|---|
| Habit Clinic for Child Guidance | 31,981 | 22,965 |
| James Jackson Putnam Children's Center | 61,586 | 36,589 |
| Judge Baker Guidance Center | 79,863 | 28,559 |
| Catholic Boys Guidance Center | 47,527 | 30,962 |
| Morgan Memorial, Hayden Goodwill Inn | 48,531 | 19,275 |
| New England Home For Little Wanderers, Longview Farm | 28,249 | 11,683 |

| *Day Care Services* | 1947 Expenditures | Fund Payment* |
|---|---|---|
| Cambridge Community Center | $ N.R. | $ N.R. |
| Dorchester House | 1,667 | 1,135 |
| Elizabeth Peabody House | 2,106 | 1,207 |
| Goodwill House | 2,981 | 1,815 |
| Hale House | 2,917 | 1,564 |
| Harriet Tubman House | 6,539 | 4,516 |
| Hecht Neighborhood House | 16,930 | 9,721(a) |
| Jamaica Plain Neighborhood House | 740 | 682 |
| Malden Industrial Aid | 5,144 | 1,103 |
| Morgan Memorial | 13,003 | 4,345 |
| Norfolk House Center | 1,858 | 962 |
| North Bennet Street Industrial School | 9,193 | 6,350 |
| North End Union | 6,550 | 2,488 |
| Olivia James House | 2,478 | 1,756 |
| Robert Gould Shaw House | 7,466 | 3,665 |
| Rebecca Pomroy House | N.R. | N.R. |
| Roxbury Neighborhood House | 1,500 | 843 |
| Ruggles Street Nursery School | 17,314 | 13,199 |
| South End Day Nursery | 19,445 | 8,041 |
| South End House Nursery | N.R. | — |
| Sunnyside Day Nursery | 10,466 | 6,298 |
| Trinity Neighborhood House | 1,532 | 430 |

(a)From Associated Jewish Philanthropies.
N.R. No Report.
*Estimated in case of Settlements and Neighborhood Houses.

VOLUNTARY CASEWORK DIVISION, Concluded

| *Rehabilitation* | 1947 Expenditures | Fund Payment |
|---|---|---|
| Bay State Society for Crippled and Handicapped | 83,973(a) | — (b) |
| Boston Guild for the Hard of Hearing | 25,344 | 11,070 |
| Boston T. B. Association, Sheltered Work Shop | 28,130 | — (b) |
| Community Workshops | 98,556 | 31,991 |
| Division of Vocational Rehabilitation | N.R. | — |
| Lend-A-Hand Society | 10,678 | 444 |
| Morgan Memorial, Goodwill Industries | 629,858 | 10,000 |
| Sarah Fuller Foundation, Little Deaf Children | 9,024(c) | — (b) |
| Shut-in Society | 3,215 | — (b) |
| Women's Educational and Industrial Union, Bureau of Occupations for Handicapped Women | 5,087(d) | 3,522 |

(a)For fiscal year ending September 30, 1947.
(b)Not member of Community Fund.
(c)For fiscal year ending May 31, 1948.
(d)Estimated exclusive of overhead and administrative expenditures.

| *Service to the Aged* | 1947 Expenditures | Fund Payment |
|---|---|---|
| Annah F. Osgood Home | $ 13,134(a) | — |
| Baptist Home of Massachusetts | 54,794(a) | — |
| Burnap Free Home | 18,401(a) | — |
| Cambridge Homes for Aged | 42,998 | 171 |
| Concord Homes for the Aged | 5,445(a) | — |
| Elizabeth E. Boit Home | 7,400(a) | — |
| Episcopal City Mission, Morville House | 42,439(a) | — |
| Everett Home for Aged Persons | 5,976 | 1,375 |
| Fitch Home, Inc. | 28,696(a) | — |
| Frances Merry Barnard Home | 15,394 | — |
| Fredericka Home, Inc. | 21,396(a) | — |
| Fuller Trust, Inc., The | 67,877(a) | — |
| Hebrew Home for the Aged | 163,651(a) | — |
| Home for Aged Couples | 95,129(a) | — |
| Home for Aged Men | 49,491(a) | — |
| Home for Aged Methodist Women | 13,381(a) | — |
| Home for Aged People, Stoneham | 10,923(a) | — |
| Home for Aged Women | 100,395(a) | — |
| Home for Aged Women in Woburn | 8,158 | 2,200 |
| International Order of the Kings Daughters | 20,710(a) | — |
| Leland Home for Aged Women | 16,721(a) | — |
| Lexington Home for Aged People | 14,255(a) | — |
| Little Sisters of the Poor (Roxbury) | 76,112(a) | — |
| Little Sisters of the Poor (Somerville) | 88,800(a) | — |
| Malden Home for Aged Persons | 21,586 | 4,400 |
| Maria Hayes Home | 14,994 | 4,412 |
| Massachusetts Home | 38,919 | 13,735 |
| Medford Home for Aged Men and Women | 11,450(a) | — |
| Mt. Pleasant Home | 47,992 | 4,039 |
| Norwegian Old Peoples Home | 10,388(a) | — |
| Old Ladies Home Association | 5,703(a) | — |
| Reading Home for Aged Women | 8,502(a) | — |
| Resthaven Corp. | 34,354 | 6,821 |
| Roxbury Home for Aged Women | 24,704(a) | — |
| Somerville Home for Aged | 34,435(a) | — |
| Stone Institute and Newton Home | 33,272 | 1,800 |
| Trinity Church Home for Aged | 15,446(a) | — |
| Watertown Home for Old Folks | 5,396(a) | — |
| William B. Rice Eventide Home | 27,862(a) | — |
| Winchester Home for Aged People | 19,267(a) | — |

(a)For 1946, as obtained for Survey Study of Total Expenditures; agency is not member of Community Fund.

## RECREATION AND GROUP WORK DIVISION

*Note*: Included in this list are the voluntary agencies discussed in the full Report; it is not a comprehensive list of all agencies in the Recreation and Group Work Division. 1947 figures for all Scout organizations are not yet available. 1946 expenditures for 11 Boy Scout Councils serving the Greater Boston Area were $155,337 and payments from Community Funds were $119,626. These figures have been adjusted to exclude any expenditures of the Councils for Scout programs in communities outside the Greater Boston Area and all camp operations. 1946 expenditures for Girl Scouts — excluding camp operations — were $130,264; Fund payments, $95.638. These figures include reports for Girl Scout programs in all cities and in the majority of towns of the Greater Boston area.

| | 1947 Expenditures | Fund Payment |
|---|---|---|
| All Newton Music School | $ 21,590 | $ 5,541 |
| Boston Music School | 24,111 | 7,655 |
| Boston Y. M. C. A. | 919,970 | 154,061 |
| Boston Y. M. C. Union | 171,558 | 34,814 |
| Boston Y. W. C. A. | 387,069 | 141,889 |
| Boys' Clubs of Boston | 223,678 | 169,547 |
| Burroughs Newsboys' Foundation | 60,913(a) | 66,985(a) |
| Cambridge Community Center | 21,813 | 14,016 |
| Cambridge Neighborhood House | 13,317 | 11,000 |
| Camp Fire Girls, Council for Greater Boston | 18,869 | 13,958 |
| Canton Youth Committee | 3,666(b) | 2,400(c) |
| Children's Art Center | 5,290 | 4,775 |
| Children's Museum | 36,774 | 7,868 |
| Cohasset Community Center | 6,005(b) | 2,800(c) |
| Community Recreation Service | 44,189 | 27,377 |
| Dedham Community Association | 7,511 | 6,000 |
| Denison House | 36 639 | 28,199 |
| Dorchester House | 27,136 | 18,720 |
| East Boston Social Centers | 41,410(d) | — |
| East End Union of Cambridge | 12,164 | 10,546 |
| Elizabeth Peabody House | 62,442 | 34,762 |
| Ellis Memorial and Eldridge House | 39,274 | 27,366 |
| Girls' Clubs of Boston | 46,656 | 36,057 |
| Good Will Neighborhood House | 26,299 | 17,323 |
| Gray Houses, Inc. | 20,530 | 20,235 |
| Hale House | 18,438 | 10,300 |
| Harriet Tubman House | 18,766 | 15,897 |
| Hattie B. Cooper Community Center | 13,197(d) | — |
| International Institute (Total Program) | 35,839 | 31,041 |
| Jamaica Plain Neighborhood House | 14,906 | 13,012 |
| Lincoln House | 55,007 | 8,638 |
| Little House | 15,510 | 12,121 |
| Margaret Fuller House | 24,820 | 11,850 |
| Norfolk House Centre | 57,426 | 33,850 |
| North Bennet Street Industrial School | 92,379 | 51,671 |
| North End Union | 37,187 | 16,681 |
| Olivia James House | 20,520 | 13,659 |
| Rebecca Pomroy House | 10,812 | 5,174 |
| Robert Gould Shaw House | 36,609 | 23,584 |
| Roxbury Neighborhood House | 33,220 | 22,664 |
| South End House | 75,305 | 37,102 |
| South End Music School | 26,828 | 9,800 |
| Trinity Neighborhood House | 26,043 | 9,878 |
| Wells Memorial | 27,979 | 14,000 |
| West End House | 37,481(d) | — |
| West Newton Community Center | 7,365 | 5,618 |

(a) Exclusive of expenditures of $41,349 for Agassiz Village and Fund payment of $10,000 for campers hips for boys attending Agassiz Village. The excess Fund payment in 1947 was applied to the 1946 deficit.
(b) Budget for 1948.
(c) Fund allotment for 1948.
(d) For 1946.

| PLANNING AND FINANCING DIVISION[a] | 1947 Expenditures | Fund Payment |
|---|---|---|
| Cambridge Community Council | $ 9,280[b] | $ 8,088[b] |
| Cambridge Community Federation | 13,993 | 13,993 |
| Canton Community Chest and Council | 100 | 100 |
| Greater Boston Community Council | 198,808 | 181,523 |
| Boston Health League | (5,479) | (17,500) |
| Greater Boston Nursing Council | (5,392) | |
| Hospital Council of Boston | (5,814) | |
| Social Service Index | (45,335) | |
| Volunteer Service Bureau | (11,841) | — [c] |
| All other services | (124,947) | — [c] |
| Greater Boston Community Fund | 457,027 | 457,027 |
| Campaign | (221,371) | (221,371) |
| Public Information | (80,120) | (80,120) |
| Year-round Services | (155,536) | (155,536) |
| Malden Community Chest and Council | 1,300 | 1,300 |
| Medfield Community Chest | 350 | 350 |
| Needham Community Council | 2,450 | 2,450 |
| Newton Community Chest | 18,975 | 18,975 |
| Newton Community Council | 5,023 | 4,995 |
| Somerville Community Council | 500 | 500 |
| Wakefield Community Chest | 50 | 50 |
| Waltham Community Fund | N.R. | N.R. |
| Waltham Social Welfare Council[d] | N.R. | N.R. |
| Wellesley Community Chest and Council[e] | N.R. | 1,160 |

[a] Included in the list below are those local chests and/or councils, members of the GBCF, which receive an allotment for administration of the local chest or council office. In addition, the expenditures for United Settlements of Greater Boston, 1946, are given.

[b] Includes $3.500 allocated by the Cambridge Community Federation for a boys' work program.

[c] Assignment of Community Fund Payment to other than Health and Hospital Division and Social Service Index not made.

[d] Waltham Fund was accepted for membership in GBCF in 1947. The Waltham Fund received $700 and the Waltham Council $150 from the GBCF in 1948.

[e] In 1948 the Wellesley Community Chest and Wellesley Community Council were combined. The figures as given apply to the Council only; the Chest receives services from the Boston Fund and Boston Council offices.

N.R. No Report.

# PART TWO

## III. Principles of Action

In this Part we set forth some of the conclusions to which the long conduct of this study has led us. These conclusions are based upon and drawn from our full Divisional Reports in the six Survey fields. In Part Three the substance of each Divisional Report is presented as briefly as is consistent with accuracy and the importance of the subject treated.

Here we present these conclusions in the form of *principles of action*, which we think should govern the future steps to be taken by the people of Greater Boston in order to put our recommendations into effect. Illustrative material under each principle of action makes evident its applicability to Greater Boston. For every illustration given, many similar cases have come to our attention. A reader acquainted with these principles of action will more readily understand the material which follows in Part Three and the full Divisional Reports which are there summarized.

The term "voluntary community funds," as used in Part Two, means moneys contributed by the general public in response to a mass appeal like the annual Community Fund Campaign.

1. *Governmental agencies, charged with the legal duty to render certain services to people who meet clearly stated conditions, should fully perform that duty, and should be provided with large enough appropriations to enable them to do so. Voluntary agencies should not use voluntary community funds to pay for such services.*

This statement sounds like — and indeed it is — both a legal and a moral axiom. But it is an axiom too often honored in the breach. A conspicuous example is the failure of public welfare departments to provide basic maintenance service for homeless and transient persons. In the face of this failure, voluntary agencies have felt forced to provide a great deal of such service. Voluntary contributions have thus been paying for what tax funds should pay.

Persons who can legally qualify for Aid to Dependent Children have a legal right to that form of public assistance. It is the obvious duty of public welfare departments to advise applicants entitled to ADC that they qualify for such grants. But grants under ADC are more generous than General Relief grants. Hence it looks like a saving of the taxpayers' money to put on the General Relief rolls persons who have a right, if they only knew it, to the larger grants of ADC. We found cases where the evidence strongly indicated that this had been done. But savings achieved in this manner not only deprive men, women and children of something to which they are fully entitled; such savings also, by forcing people to accept what are often inadequate grants, impose on voluntary agencies a virtual obligation to supplement many such grants. Voluntary funds so used are misused, and to the extent of such misuse voluntary agencies are prevented from realizing their true purpose.

The rehabilitation of adjudicated delinquents is recognized as a governmental responsibility. Temporary detention facilities are indispensable in such rehabilitation. Yet throughout Greater Boston there have been no tax-supported temporary detention facilities for adjudicated delinquents. Some voluntary agencies provide such protection for a limited number of young people. Two unfortunate results are thus assured: First, by no means all the adjudicated delinquents who are entitled to this service receive it; second, the voluntary funds thus used cannot be used for other more appropriate and sorely needed services, services that tax-supported agencies cannot render. If the governmental agencies concerned were performing their full duty, both of these unfortunate results would be avoided.

A corollary of our first principle may be stated as follows:

*When the provision of certain services has become widely accepted as a proper duty of government, it is mistaken community policy to support such services indefinitely from limited voluntary contributions.*

In a Metropolitan town a voluntary agency has for more than twenty-five years been operating a playground and play field on a large park-like area in the center of the town. The Community Fund has been helping to support it. Such a service is clearly of a kind that cities and towns support from tax funds. The Community Fund has also been helping to support a museum for children, — again a kind of service that local governments should support from tax funds. Private philanthropists may wish to contribute to such services as these, and they are certainly free to do so. We do not think limited voluntary community funds should be so used.

Many more cases could be cited. Two from the health field will suffice. Forty-seven of the fifty-five communities in the Greater Boston Area have dental services open to children on a pay, part-pay

or free basis, as circumstances of need may indicate. The propriety of supporting services of this sort from tax funds is now generally accepted. Yet five of these communities still do not provide tax funds for dental service to children. In other communities, dental services now supported by tax funds were first established with voluntary funds as demonstration projects. Why should voluntary funds continue to support such services? We see no reason.

A similar movement of public opinion has taken place regarding nutrition services. When first started, costs of nutrition services were almost everywhere borne by voluntary funds. The widespread importance of such services has been established, and more and more they are now a part of the program of official health departments. This shift of financial support should be hastened.

2. *A tax-supported agency which obtains, in the performance of its legal or chartered duty, service from a non-profit making social or health agency should reimburse to the latter the full cost of such service. Voluntary community funds should not be used to subsidize, in whole or in part, the purchase by government of such service.*

Repeated instances of violation of this principle will be found in our Divisional Reports. The effect on agencies receiving Community Fund monies is in many cases extremely serious.

A glaring illustration is the failure of most departments of public welfare to reimburse to voluntary hospitals the full cost — or, in some cases, *any* of the cost, — for medical care of public assistance clients who are the legal responsibility of such departments. This failure is notorious and, in our view, indefensible as a matter of policy. The cost of medical care for those on public assistance is as much a public responsibility as the cost of their food, shelter, clothing, etc. It is estimated that the loss in one year to four large Boston general hospitals alone, because of failure of public agencies to reimburse these hospitals for medical care of such public agencies' clients in *all* categories, amounted to $350,000.

Again, the City of Boston will not make any payment to the Visiting Nurse Association of Boston for nursing visits to the City's public assistance clients in their homes. These visits cost the Association $32,000 a year. It is the policy of the State Department of Public Welfare that local boards of welfare shall reimburse for such nursing visits. Other communities in the Commonwealth observe that policy: the City of Boston does not.

The diversion of voluntary community funds virtually forced on budget committees and voluntary agencies by such defaults of public agencies runs into hundreds of thousands of dollars a year. Until the practices described above are changed, and our second principle is generally observed, voluntary community contributions will not be able to serve the purpose for which they are intended.

We may add here that certain non-Fund *voluntary* agencies use the Social Service Index, without paying the full cost of indexing and clearing their cases. As a result, contributions to the Fund made for the use of Fund agencies are in part used to pay the operating costs of agencies that are not members of the Fund and that raise their own money for their own purposes. The contributing public expects Fund monies to go to Fund agencies.

Principles 1 and 2 are given priority, because their observance will help to give people a clearer picture as to which activities should be carried on by tax-supported agencies and which activities fall in the proper sphere of voluntary agencies. The line between the two is always shifting; but stubbornness in resisting change, or the slowness of a few communities in accepting what is prevailingly accepted elsewhere, only intensifies popular uncertainty and doubt. Voluntary effort, as the long history of social and health services eloquently attests, has been indispensable in raising all services to what, at their best, is a highly effective state. Its distinguishing function is still that of experimenting, pioneering, demonstrating, refining, enriching. It cannot discharge that function if virtually forced to assume responsibilities for basic services that are generally recognized, and even legally accepted, as the responsibilities of government.

3. *Some services, now supported by voluntary community funds, should from their very nature be self-supporting; and the use of voluntary community funds for such services should be discontinued.*

Again we seem to be stating an axiom. Although the situation is not always so simple as to be axiomatic, we are confident our third principle is sound.

In Greater Boston, for example, the Community Fund has been making contributions to music schools and to a trade school. When these schools were founded, it was logical to finance them from voluntary contributions. But circumstances have changed. On the one hand, public school systems now offer far more in the way of musical instruction and trade school opportunities than they did some years ago. On the other hand, the gap is widening between total agency requests for Fund grants and the maximum grants the Fund finds it possible to make. Choices are forced on Fund budget committees.

If private schools can support themselves by tuition fees and limited help from private philanthropists; if an ever larger number of young people can receive from public schools a substantial measure of the instruction they have been receiving from private schools which the Fund has been helping to support; and if many agencies rendering a vital service that no public agency offers are largely or wholly dependent on Fund grants; — in such circumstances, is there any doubt what choice should be made? Community Fund and other limited voluntary community support should go where it is indispensable for the most sorely needed services.

Other illustrations will be found in our Reports. The ones presented above establish the principle.

To summarize all the foregoing: If tax-supported agencies will perform in full the duties with which they are charged by law, and social and health legislation will keep reasonably abreast of general acceptance; if non-profit agencies can be reimbursed at full cost for services they render to tax-supported agencies in the discharge of the latter agencies' legal obligations; and if agencies that can be self-supporting will exert themselves to become self-supporting; — then there will be released a considerable part of the annual voluntary community contribution for application to more basic and widespread human needs.

It remains to consider what must be done to make sure that voluntary contributions can attain maximum effectiveness in their proper sphere. This task leads to the statement of a group of principles based on a different but no less valid set of assumptions.

4. *No agency supported by voluntary community contributions should needlessly duplicate or overlap services of another agency.*

The governing principle of this Survey — as it should be the principle governing social and health agencies in every community — is to make sure that the charitable dollar "does the greatest good for the greatest number in the most economical, effective way." The charitable dollar cannot achieve maximum economy and effectiveness unless it is stretched as far as it will go. It is not stretched as far as it will go if some parts of it are used to support certain voluntary services and other parts of it are used to support similar voluntary services needlessly covering the same ground. It is not enough to argue that Agency A, though doing the same kind of work as Agency B and for the same kinds of people, does not duplicate or overlap Agency B because the two agencies do not serve the same identical persons. Duplication and overlapping can exist between overhead charges and costs of administration and supervision, as well as between direct services or direct service charges. Duplication and overlapping, of whatever kind, create confusion in the public mind. They produce uncertainty; lost motion in applying for help; confusion in the minds of referring agencies, which causes delayed or improper referrals; hesitancy in making contributions. Thus, both directly and indirectly, duplication and overlapping waste money. Only when agencies have firm, clear definitions of function, as nearly mutually exclusive as practicable, and when lines of referral are clear and well understood, can it be said that there is no needless duplication or overlapping of services between community agencies.

Anyone familiar with the pattern of voluntary agencies in large eastern communities would know in advance that we could not fail to find duplication and overlapping as defined above. The point does not need to be labored or specific illustrations cited. Duplication and overlapping of services abound in the non-sectarian family service field; in the voluntary non-sectarian child care field; in the public health nursing field; in Neighborhood House and Settlement work; and in many other fields. The difficulty lies not in recognizing the fact that duplication and overlapping exist, but in suggesting changes that will both dispense with these twin weaknesses and retain such measure of loyalty to specific agencies as gives strength to the whole charitable movement. We have proceeded boldly in this regard, for we are convinced that loyalty to the movement is larger and more important than loyalty to specific agencies, and that the larger loyalty will prevail. We do not think we are "throwing out the baby with the bath."

Several courses of remedial action are possible when steps must be taken to get rid of the kind of duplication and overlapping discussed above. The circumstances of each case will indicate which course is to be preferred.

*(a) Some agencies should transfer their functions to other agencies and go out of existence.*

In 1920 a separate agency was established to plan in the field of recreation and to conduct demonstrations of recreational services. It has done fine work. But since 1920 the Greater Boston Community Council has become a more inclusive planning body, embracing the field of recreation; and we have submitted recommendations for a greatly strengthened planning body. As to the field of demonstration, general acceptance of recreational services, both tax-supported and voluntary, has progressed to

a point where maintenance of a separate agency primarily for demonstration seems a costly and not obviously needed enterprise. We think, in an age when every penny must be watched, other existing organizations can undertake these services.

A Seamen's Home, founded to help seamen who were Lutheran and especially both Lutheran and Swedish. is finding with the years that few of its beneficiaries are either Lutheran, Swedish, or even seamen. Other agencies exist to serve the kinds of people this Home has latterly been serving. Its officers themselves recommend its dissolution. We endorse that recommendation.

Certain voluntary agencies of ancient origin, which take care of unattached, homeless and transient men, have a heavy proportion of alcoholics among their clients. It is the clear duty of public welfare agencies to provide basic shelter and maintenance for the unattached, homeless, and transient. Other specialized voluntary agencies are better equipped than those here in question to care for the problems of alcoholism. Therefore, we believe that the agencies first referred to should be discontinued.

*(b) Some agencies, while remaining in existence, should devote their energies to their primary functions and eliminate cerain corollary functions they have assumed, referring clients who require the service of such corollary functions to other agencies.*

As time passes, it is natual enough for agencies to tend to expand their original programs by adding certain other and not too closely related services which are the primary function of other specialized agencies; as, for example, the addition of fairly extensive libraries, dental and medical service, day-care centers for young children, casework and nursing service. We see this gradual encrustation of all kinds of services in agencies in various fields. We do not doubt that it is more convenient for a child enjoying the play programs of Agency A also to have dental treatment on the premises instead of being referred to a dental clinic; but can we today afford expenditures based on such convenience? Less self-sufficiency within each agency and more referral is today desirable. We recommend that these agencies divest themselves of services not germane to their central purpose and allow specialized agencies to provide these added services.

Perhaps our most searching recommendations falling under this heading will be found in the voluntary child care field. Greater Boston has a number of strong voluntary agencies rendering child care services, each agency pre-eminent, or able easily to become pre-eminent, in some important specialty in this field. But the tendency has been for each agency to render some kind of service in virtually all the specialties, to become a jack-of-all-child-care-trades. The result has been lamentable confusion in the mind of everyone — the contributing public, other agencies wishing to make the best possible referrals, and certainly the clients. We recommend vigorous steps to clear up this confusion by selecting one of the strong agencies to specialize in each important aspect of voluntary child care and thus to become the community's acknowledged major resource in that specialty. Each agency so selected should transfer to the other selected agencies the functions that are appropriate to their respective new specialties. We are confident that, by thus making the field of specialized voluntary child care more orderly, our recommendations will improve effective work among child care agencies.

We make recommendations of this general sort affecting so many agencies that to give a full picture of the results here is impossible. The point is clear, and to us it seems unarguable.

*(c) Some agencies, to preserve and strengthen their values, and for greater economy and effectiveness of operation, should merge and consolidate to form stronger units.*

Under this heading, we make recommendations affecting many agencies. A few brief illustrations follow.

Prompt merging under unified Board and staff direction, followed by complete corporate consolidation, of Settlement and Neighborhood Houses in fairly close proximity to each other and serving the same general area. Our recommendations would cut the number of these agencies in half and provide fewer and stronger agencies, giving better and more economical service.

Affiliation of a children's agency specializing in the sick child with a hospital for children; thus improving the medical care and supervision that can be given to the sick children whom the agency will continue to place in foster homes.

Merging under unified administrative direction — as they are now under unified ecclesiastical direction — of the Catholic Charitable Bureaus of Boston, Cambridge, and Somerville.

Creation of a new, inclusive non-sectarian Federation for family service, which will incorporate all the present strengths of the two great family service agencies of Boston proper (which spend over $500,000 a year and offer similar services in the main to the same population); this Federation to include,

as soon as practicable, the twelve non-sectarian family agencies in the Metropolitan Area, many of which are so small as to be uneconomical operating units, and to carry on its activities through Social Service Centers so placed throughout Greater Boston as to make family and related casework services accessible to all parts of the Area; and these Centers to act as screening and referral centers for all applicants for social services in the territory they serve.

Creation of a new Day Care Association for the economical and expert administration, through specialized centers, of day-care services for pre-school children, which services at present are diffused among a score of agencies.

We are confident that such mergers and consolidations will produce both significant operating economies and far more effective service per dollar of cost. Of course, we are mindful that size alone does not insure excellence of performance.

*(d) Some agencies should affiliate to provide a needed service.*

One instance, a many-sided one, will suffice to illustrate this principle. The Wells Memorial Association operates a small educational and recreational center in a decrepit building in downtown Boston. The Young Men's Christian Union has an excellent downtown location, but its old building is not worth the expense of remodelling to enable it to meet the needs of the area. The Burroughs Newsboys' Foundation has a downtown building, but its program is too expensive for the relatively few boys it serves. The YMCA has no downtown building. The YWCA needs a new residence for girls to replace its ancient Berkeley Street residence. We recommend, by progressive steps, the merger of the first two agencies and the merger of the third and fourth agencies; a consolidation of the operations of these agencies in a new and superior Downtown Center to replace the present building of the YMCU, at or near its present site; a part of such new building also to serve as a residence for girls to meet the needs of the YWCA; and development of a co-educational program in this new building that will carry forward the excellent co-educational work now being done by the YM and YWCA.

There are more aspects of this recommendation than are covered by this too brief statement, but the point should be clear. If agencies, especially weak agencies, can rise above their often intense and even admirable self-loyalty, services can be developed through joint action that will be more effective than that which even strong separate agencies are now doing.

*(e) Through joint conference, agencies should enter into agreements that will clearly define areas of their service that are now in doubt or insufficiently understood.*

An excellent illustration of the need for agreements reached through such joint conference, and of the more effective service that should result, is offered by the existing confusion that is found between family agencies and medical service departments of hospitals. During periods of hospitalization, many patients have financial needs, and worries about the financial and other needs of their families, that affect recovery. Where is the line to be drawn between meeting such needs as a part of medical treatment (presumably a responsibility of the medical social service departments), and meeting such needs as primarily a normal casework service to the families involved (presumably a responsibility of family agencies)? Who is to draw the line? This is clearly a case for cooperative discussion and agreements reached by consent. We recommend the conclusion of such agreements.

Somewhat similar situations exist in Cambridge and Newton as between tax-supported agencies and voluntary agencies. Here the primary difficulty lies in the fact that neither group of agencies knows enough about, or takes advantage of, the facilities of the other group. We recommend joint study and cooperative programs.

5. *Where serious gaps or weaknesses in service are revealed, they should be filled or remedied as promptly as possible. As far as practicable, existing agencies or combinations of agencies, rather than new agencies created for the purpose, should be utilized in this process.*

We found a lack of specialized information and referral centers to supplement and extend the admirable general information and referral service of the Greater Boston Community Council. In a community as large as Greater Boston, with so many and such varied services, specialized information and referral centers are indispensable to prompt and accurate referrals. We recommend the organization of several such specialized services and centering them in existing strong agencies; for example, in Community Workshops, for the rehabilitation field; in the Social Service Centers of the proposed Federation for family service, for family service and related fields for the Metropolitan Area; in the Children's Aid Association, for the child care field.

Believing strongly in the superiority of a generalized public health nursing service over fractionalized nursing services, but knowing that many obstacles must be overcome before so drastic a

reorganization is practicable in the complex community of Greater Boston, we recommend selection of a demonstration area in Boston in which the Boston Department of Health, the Visiting Nurse Association of Boston and the Boston School Committee combine to render a generalized nursing service, in order to determine its economies and effectiveness.

The Greater Boston Community Fund now makes its allotments to hospitals on the basis of annual operating deficits, with little or no relation to the residence of patients or to the number of units of service given to eligible indigent patients. It would be far preferable if Fund allotments could be based on measurable units of service. We recommend a formula for deriving comparable, measurable "units of community service"; for determining the loss suffered by each hospital in rendering such units of service; and for determining the number of such units for which each hospital should be reimbursed by the Community Fund (within the total amount of Fund monies allocated to hospitals); such formula to be put into effect only after further study.

6. *Workers in all agencies should know the community resources on which the nature of their work requires them to call.*

It may be heavy-handed to elevate this elementary and obvious truth to the dignity of a principle of action. But if one thing more than any other was borne in on the Survey staff during their field work, it was the immense lack of information — in some cases even lack of interest — about the services of agencies other than their own that marked too many of the workers with whom we talked. Our Divisional Reports, and the specialized Reports on which they are based, contain abundant testimony on this point — notably in the fields of public welfare, vocational counseling, care of the aged, rehabilitation, care of the unattached and homeless, recreation and group work, and in parts of health and hospital service. Such lack of information is serious. It results in delayed or wrong referrals, or perhaps no referral at all, and thus renders a grave disservice to clients.

Remedies for this lack of knowledge are of at least three kinds. One can be applied by each worker to himself: he can exert himself to become better informed about community resources. A second lies within each agency: through staff conferences and in-service training, it can broaden the knowledge of its staff, and we recommend this step in many fields. A third remedy lies with the Greater Boston Community Council: in every way at its disposal, it can press for increased knowledge of the community by every professional and lay worker in every agency.

7. *Agencies, whether tax-supported or voluntary, should have a strong enough financial base, and a large enough work load, to make possible and justify a competent, well balanced staff. Where this is not now the case, combinations of agencies should be effected to improve and strengthen the service.*

Under an earlier principle, illustrations have already been given to which this principle also applied — notably, the small family agencies in the Metropolitan Area. Other services in the Metropolitan Area can be cited here.

The two most conspicuous illustrations involve tax-supported agencies and hence will require legislative action. The agencies concerned are official health departments and departments of public welfare.

There is general agreement among health administrators that health services should be administered on the local level, but that local administrative units can be, and often are, too small for either economy or efficiency. Modern health practice insists that a balanced team of specialists is required to carry on an effective program, and if the team is too small it simply cannot include all the specialists that are needed. Experience has demonstrated that a population grouping smaller than 50,000 cannot yield enough tax money to support even the minimal team required for an effective health service. Hence a city or town of appreciably less than 50,000 population, as long as it has an official health department of its own, is fated to be wasteful and ineffective in its health work. In many states this difficulty has been overcome by legislative action that makes it possible — in certain circumstances even mandatory — for small governmental units to join in a single "Health Union" whose population is large enough to provide tax income that makes possible a health team that can do effective work. There are 27 cities and towns in the Metropolitan Area of appreciably less than 50,000 population. We recommend the formation of ten "Health Unions" in that Area.

The same logic applies to small departments of public welfare. They are prevented by their very smallness from doing the economical and effective work to which their communities are entitled. We therefore recommend that contiguous cities and towns in the Metropolitan Area, wherever it will be practicable and advantageous to do so, constitute larger units for the administration of local public welfare.

To small voluntary agencies the same principle applies. The 43 Visiting Nurse Associations in the Metropolitan Area provide a good many cases in point, just as the small family agencies do. These 43

Visiting Nurse Associations employed 135 nurses in 1946 — an average of 3 nurses per Association. Many of the Associations are therefore two or even one nurse organizations. No V. N. A. that small can possibly be as efficient as one large enough to provide adequate supervision and specialized consultation service for its staff nurses. Other steps should be taken first to bring order into the public health nursing situation in the Metropolitan Area; but in due course the many small independent Visiting Nurse Associations should be reorganized into larger units. We do not think voluntary community funds should be used indefinitely to support inefficient units.

It is thus apparent that we have been led, by an examination of specific local situations, to a belief that in the Metropolitan Area of Greater Boston the principle of "regionalization" should be applied to many services. We apply it also to the chests and councils in that Area. The effectiveness of chests and councils is largely dependent on staff service. At present a small staff divided between the Greater Boston Community Fund and the Greater Boston Community Council is undertaking to organize and to serve chests and/or councils in virtually every city and town in the Metropolitan Area. The job is too large for any staff that the Greater Boston Community Fund and Council can be reasonably expected to afford. So here again we recommend "regionalization" — the eventual grouping of cities and towns into natural districts, and wherever appropriate the formation of a chest and/or council for each district. As this movement progresses, it may be practicable to give adequate staff service to all such Metropolitan district chests and councils.

8. *Full advantage should be taken of opinion and practices prevailing throughout the country under which the costs of certain tax-supported services are shared between local and state, or among local, state and federal governments.*

The best known instances of such sharing of costs are the several categories of public assistance, including General Relief. Except for "unsettled" cases, Massachusetts law does not make possible state reimbursement to cities and towns for any part of the cost of General Relief, such cost being borne wholly by individual cities and towns. We understand that opposition to state reimbursement for General Relief exists chiefly among local officials, who fear "state interference and control." This seems to us a clear case of permitting a sentiment admirable in itself — local pride and self-reliance — to work to the disadvantage of the public. Not only would a policy of state reimbursement for General Relief ease the burden on local taxpayers; it would also bring to the assistance of local public welfare offices the advantages of state guidance.

9. *Personnel requirements should be raised, personnel practices strengthened and made uniform, and preferences not based on competence should be subordinated to preferences based on qualifications for the work to be done.*

Almost without exception, our Divisional Reports stress the lack of adequately trained and experienced staffs found in their respective fields; the low salary scales that prevail; the small number of suitable codes of personnel practices in effect, and the diversity between such codes as have been prepared, with resulting effects on staff morale and turnover that are unfortunate; and the blighting influence on the public service that flows directly from the existing State policy of granting in Civil Service ratings a preference to veterans. It may be said that Greater Boston is not unique in all these respects. There are not enough well trained social and health workers to staff all agencies; and the pressure for more adequate salaries and better working practices makes slow headway in a field only slowly establishing itself as a profession. But if not unique, neither is Greater Boston showing much leadership in the struggle for improvement.

Personnel weaknesses are so general that it is unnecessary and indeed fruitless to particularize. The wide gap we found between current practice and the levels, standards and procedures recommended in the personnel studies recently issued by the Greater Boston Community Council, is well known to the Boards of Directors and administrative heads of local agencies. Particularly deplorable is the inevitable deterioration of the public service under existing Civil Service legislation, rules and regulations.

It should be obvious that good work can be done only by good workers, and that good workers can be attracted and held only by making salaries and working practices commensurate with the results desired. True and important at all times, this consideration is of special moment in Greater Boston now. Many of our recommendations are so drastic and far reaching that nothing but first-class intelligence, the best of training, and the most mature experience will suffice to carry them out. Those qualities are not easily come by; but if the reasonable hopes and desires of all who sponsored this Survey are to be fulfilled, those qualities must be found and held in much larger measure than is now the case. That can hardly be done without better and more uniform personnel practices.

10. *There should be established a strong central agency for the purpose of planning the social and health services of Greater Boston, raising voluntary funds to carry out such plans, and budgeting the funds so raised. This agency should be well led, well financed, well staffed, backed by strong public opinion, and representative — not predominantly of member agencies — but of all interests in the community. Representatives of public and voluntary agencies should participate in this planning.*

It should hardly be necessary to labor the importance to Greater Boston of sound social and health planning. Every one of our Survey Reports underscores that importance. Indeed, it was recognition of the need for strong and vigorous planning that called the Survey into existence.

Planning is now being done by the Greater Boston Community Council, which is corporately separate from the Greater Boston Community Fund (though it can hardly be said that the budgeting activity and many other activities of the Fund are not also planning). The principle set forth above calls for a single organization to plan, raise funds and budget the funds raised. In most large eastern cities, funds and councils are corporately separate. So far as we know, few people regard the question of whether such organizations should be two or one as a question to be answered always in the same way and on principle. Rather, most people think the question should be answered for each community on the basis of what will best meet conditions in that community. Our reasons for recommending a single organization for Greater Boston are fully set forth in our Divisional Report on Planning and Financing, and are summarized in this Report.

Much more fundamental — and here we do deal with a matter of principle — is our conviction that planning in the social and health field should be shared by representatives of both tax-supported and voluntary agencies. Unless such sharing becomes habitual and the accepted thing, tax-supported and voluntary activities will go their separate ways, and a program that should be unified in conception and purpose, though its parts must be separately administered, will tend to be divided at every turn and fall far short of maximum effectiveness.

Also fundamental and a matter of principle is our conviction that planning should not be controlled by delegated representatives of member agencies of the planning body, much less by delegated representatives who are staff members of those agencies. Delegated representatives quite naturally, and in a sense quite properly, tend to be protective of the organization they have been named to represent. Social and health planning should be protective of only one thing — the welfare of the entire community. That kind of planning requires the participation of a strong lay element whose first concern is the community as a whole.

The foregoing are the major principles of action that our observations and analyses have convinced us should be followed. To the extent that they are followed in the future, we are confident the social and health needs and services of Greater Boston will be brought more nearly into balance.

# PART THREE

## IV. Health and Medical Care

### A. Health Services in Greater Boston

In this study of the Health Services of Greater Boston, an effort has been made to determine the present and future needs and opportunities to prevent disease, prolong life, and promote the health and efficiency of the people.

*Expenditures*

A total of $3,200,897 was spent for the public health, by tax-supported and voluntary agencies, in Greater Boston in 1946 — $1,749,127 in Municipal Boston and $1,451,770 in the Metropolitan Area.

Public health departments spent 56.3% of the total; school departments, 14.9%; nursing associations 20.6%; and other agencies 8.2%.

Per capita expenditures varied from about 45 cents in Chelsea to over $2.20 in Boston.

A comparison with 267 other communities throughout the United States (American Public Health Association 1943-1946) showed that Greater Boston's communities, with few exceptions, stand fairly well in support of their health services.

*Records*

Systematic records and vital statistics are important for the health administrator in disclosing problems toward which the program should be directed and in providing indices by which control achievements may be evaluated. For most of the communities and for many agencies, such records, including current administrative service records, are very limited or entirely lacking. It is evident that, except for Boston and possibly a few other towns, health officials must rely on the comprehensive annual State Registrar's report for adequate statistical analyses of their own vital statistics.

*General Health Services in the Metropolitan Area*

The American Public Health Association Evaluation Schedule was used in appraising the health work of 15 representative communities in the Metropolitan Area. This schedule provides a method of evaluating the health program and facilities of a community as a whole and is not limited to work of the official health department. Stress is placed on accomplishments rather than methods, and on how well the work done is adapted to meeting demonstrable community needs.

The result of the application of this Evaluation Schedule to these 15 communities is shown below:

| | Activity | | Good | Fair | Poor |
|---|---|---|---|---|---|
| 1 | Water Supply and Excreta Disposal | | 9 | — | 6 |
| 2 | Milk Sanitation | | 9 | — | 6 |
| 3 | Health Education | | 6 | 3 | 6 |
| 4 | Problem Definition | | 2 | 9 | 4 |
| 5 | Tuberculosis Control | | 3 | 6 | 6 |
| 6 | School Health | | 5 | 2 | 8 |
| 7 | Basic Data | | 3 | 5 | 7 |
| 8 | Financing | | — | 10 | 5 |
| 9 | Maternal Health | | — | 8 | 7 |
| 10 | Infant Health | | 2 | 4 | 9 |
| 11 | Housing | | 2 | 4 | 9 |
| 12 | Adult Health | | 2 | 3 | 10 |
| 13 | Preschool Health | | 1 | 4 | 10 |
| 14 | Food Sanitation | | 3 | — | 12 |
| 15 | Communicable Disease Control | | 1 | 1 | 13 |
| | Total | 225 | 48 | 59 | 118 |
| | % | 100 | 21 | 26 | 53 |

In each Community studied, information was secured with respect to each of the major activities listed; thus obtaining a grand total of 225 scores. Of these scores, 21% were "good," 26% were "fair," and 53% were "poor." Water supply, excreta disposal and milk sanitation received the best grades, and

food sanitation and communicable disease control the lowest. Since more than half the grades were "poor," it is quite apparent that health practices in many of the communities studied are well below the national average.

This material — and statistics as to the people of Greater Boston and their health record — is set forth in elaborate detail in our full Division Report on Health Services.

On the following pages we undertake to evaluate current practices in major services and recommend ways in which they might be of greater benefit to the people of this community.

*Communicable Disease Control*

There are more than forty diseases which are reportable to local boards of health as communicable diseases. Some diseases, notably venereal diseases, should be reported directly to the Massachusetts Department of Public Health. Isolation and quarantine regulations are established by the State Health Department. Local departments may tighten up on State requirements if they so desire.

Procedure and practice vary in different communities. Few communities have adequate professional personnel to administer communicable disease programs or to cope with epidemics. The State Division of Communicable Diseases assists local communities in epidemics or when there is need for diagnostic consultation. Advisory service is given and special studies are conducted by this Division.

The State Department also maintains a diagnostic laboratory for bacteriological and serological examinations and a biological laboratory which prepares anti-toxins, vaccine, etc., and processes blood.

*Venereal Diseases*

Approximately 5,000 cases of syphilis and an equal number of gonorrhea cases are reported in the State, though the gonorrhea incidence is known to be much higher. Greater Boston accounts for about half of the total.

Early case finding, investigation of source, easily available adequate treatment and education are of the utmost importance in this state and local program. Specialized workers are especially important in this field.

> We Recommend: The venereal disease control program in the Greater Boston Area should be carried out by the Health "Unions" and the Metropolitan Health Authority, both described in a later section of this summary; by general hospitals; and by the Massachusetts Social Hygiene Society. Investigation, follow-up, treatment, and education would be included in an intensive and continuous program.

*Tuberculosis Control*

Tuberculosis is a communicable disease of particular importance to the public health because of its chronic character, because it usually affects family groups, and because it is one of the principal causes of death. It is an important factor in creating economic distress. The Greater Boston death rate from tuberculosis averages much higher than the State death rate; and the State death rate is no better than average in comparison with other State death rates for the United States. This situation exists, even though the State Tuberculosis Bureau has had unusually able direction. There is evidence of incomplete reporting of cases; of inadequate follow-up of community X-ray programs; of insufficient emphasis on the needs of racial, community, and age groups in which tuberculosis is most serious; of long waiting lists for institutional care; and of a lack of correlation, especially in Boston, between the work of the voluntary and the official agencies. Rehabilitation of the tuberculous suffers from the inability of the State Division of Vocational Rehabilitation to accept and handle promptly and effectively all such clients referred to it.

To the end that increasing attention may be given to some phases of the control of tuberculosis:

> We Recommend: (1) The boards and committees of the voluntary tuberculosis associations should lend their support as a priority item to the development of plans for better organized and more effectively administered local official health services.
>
> (2) Increased joint planning should be fostered between the tuberculosis associations and other voluntary and official health and welfare agencies, in order to increase the effectiveness of efforts for: (a) early detection and proper follow-up of tuberculosis; (b) early detection and proper referral of other diseases; (c) health education; and (d) rehabilitation.

*Maternal and Child Health*

The mental and physical well-being of every individual is determined in no small measure during fetal life and early childhood. Every community, therefore, should be sure that basic services are available to all its mothers and children.

The death rate of infants in the first year of life has long been taken as an index of the state of health in a community. Among the individual cities and towns of the Area, Municipal Boston is the only municipality with an excessive and significantly high infant mortality rate for the years 1941-1946 (35.5). Smaller towns or groups of towns occasionally have higher rates, but the number of deaths concerned is not such as to be significant. Similarly, maternal mortality figures for Boston are higher than those for comparable urban areas such as New York City and Chicago. (See our full Division Report for detailed figures.)

*Well-Child Care*

The successful management of the "well child" is a responsibility of the medical practitioners of Massachusetts and of Greater Boston, since it is they who now render over two-thirds of health supervision to the children in these areas. Figures from the recent Survey of the Massachusetts Study of Child Health Services show that general practitioners make 78% of all the house and office calls on children under fifteen years of age. About one-third of all the visits by general practitioners and two-thirds of the visits made by pediatricians are for health supervision.

It is evident from present information that much still remains to be done in extending health supervision to the children of Greater Boston. An appraisal of fifteen of the large communities in the area, involving 50% of the total population (2,014,013), resulted in only "fair" to "poor" scores. In eight of the towns data were not available on many items.

As operated at present, the forty-one agencies maintaining well-child conferences in the Greater Boston Area can be said to provide regular health supervision to only a small number of infants. At the time of the Pediatric Survey, 88 different centers held 3,873 sessions during the report year. The total number of patients for these 41 agencies was 28,285. There was a marked variation in the frequency of sessions (from 2 to 316 a year). Clinics at the present time furnish only a small amount of the total medical health care now being provided children in this area.

*The Immunization Program*

The immunization programs of Boards of Health and well-child conferences operated by other agencies fail to follow modern pediatric standards in many cases. The total number of immunizations performed under these auspices is not nearly sufficient to meet the needs. Because few communities have reliable statistics on the number of immunizations done by private physicians, it is impossible to state how completely the communities are protected against communicable disease.

Less than a fifth of the well-child conferences in Greater Boston provided immunization against smallpox, whooping cough, or tetanus. About one-half of the 3,873 sessions in the report year provided such service, and 40 percent of the sessions were those of the Boston Health Department.

*Education of Practitioners.*

The national survey of the American Academy of Pediatrics and its local component, the Massachusetts Study of Child Health Services, has shown that a considerable proportion of general practitioners and even pediatricians have what would be considered inadequate schooling in modern pediatric technique. It should be of immediate concern to provide better facilities for the post-graduate education of practitioners who are now conducting well-child conferences, or acting as school doctors, or whose interest or activities put them in positions of responsibility as regards the health of children. More opportunities for the post-graduate training and refresher courses for physicians in pediatrics and obstetrics should be provided by the three medical schools in the Area.

Because of the condensation here of the extended discussion appearing in our Division Report we repeat in full below our *recommendations* in this connection:

"1. *Service to expectant mothers should be improved.* This will involve:

a. Closing of existing home delivery services as planned.

b. Raising standards for maternity and new born care in hospitals. Official medical groups should be invited to participate in the revision of recently proposed hospital standards, and sub-standard hospitals should receive special attention. Any attempt to improve present conditions will require increase in the personnel of the Division of Hospitals of the Massachusetts Department of Public Health.

c. Joint action by organized medical groups (Massachusetts Medical Society, Boston Obstetrical Society, New England Pediatric Society and the Massachusetts Chapter of the American Academy of Pediatrics) and official health departments in investigating maternal and neonatal deaths. Emphasis should be placed on using the information secured for educating physicians and hospital personnel in the prevention of similar fatalities.

d. Provision of suitable consultants in obstetrics and pediatrics in every licensed hospital furnishing maternity care.

e. Closing by the State Department of Public Health of all hospitals which at the end of three years remain sub-standard.

f. A careful review of the present program for the care of all prematurely born infants. Organized action is primarily dependent on improved statistical service.

2. *Careful Study Should be Made of Organized Services Now Available for the Health Supervision of Well Children, Giving Consideration to:*

a. Transferring operational responsibility for Well-Child Conferences when possible from voluntary nursing agencies to official health departments having medical personnel or to hospitals with well organized pediatric services. The latter alternative, when resources are satisfactory, would be a practical means of coordinating service to the medically indigent and would tend to centralize all services for children, both in sickness and health. The continuity of medical care should not be broken.

b. Supplementing the present supervision of such conferences by supplying additional qualified pediatric consultants. For the Greater Boston Area, the time of at least 2 full-time pediatricians would be a minimal requirement; one for the City of Boston and one for surrounding areas. These men should be fully qualified in their specialty and should be paid accordingly. It would be desirable to have them associated with the Harvard School of Public Health. The possibility of purchasing such supervisory service should be explored.

c. Providing for greater coordination between the work of nurses and physicians operating in Well-Child Conferences.

d. Establishing more uniform immunization procedures with emphasis on protecting all infants and children of pre-school age against smallpox, whooping cough, diphtheria and encouraging immunization against tetanus.

e. Placing greater emphasis on regular health supervision for the pre-school child and the transfer of pertinent information to the school health service concerned.

f. Avoiding duplication of service by different public health nurses in home visiting.

g. Providing consultant psychiatric services to nurses and physicians working in Well-Child Conferences with a view to increasing the competency of the personnel in helping parents to develop sound mental health in their own families. Provision should also be made for helping families having such problems.

3. *Expansion should be secured of post-graduate educational programs for all physicians and nurses who care for expectant mothers and their children.*

4. *Drastic improvement should be attempted in the present system of reporting and circulating of vital statistics to the end that the mortality in mothers and children may be effectively studied and combatted."*

### *Health of the School Age Child*

Two school health programs are conducted within the City of Boston: one for public and the other for parochial school children; besides some 54 official programs in the rest of Greater Boston and exclusive of individually arranged programs in several private schools located in the Greater Boston Area. The public school health program of the City of Boston is under the administration of the Superintendent of Schools and is carried on by teachers with the assistance of physicians, nurses and other personnel employed by the School Committee. The parochial school program is a joint undertaking of the principals and teachers of those schools, with special services provided by physicians and nurses employed and supervised by the City Health Department.

Schools have recognized health as an objective of education and have developed some of the foundations for effective programs. They have employed specialized health personnel and have, in some instances at least, utilized professional personnel made available by Health Departments. They have included health education in the curriculum, in varying degrees of effectiveness. Attention has been given to handicapped children. Buildings have been inspected so as to identify hazards to health and safety. A few school systems have shown concern for the health of their employees.

For those communities which have not already started to extend their school health program:

We Recommend: (1) A school health council or committee, composed of interested professional and lay persons, should be organized in each community to plan and evaluate school health programs and to integrate them with total community health programs.

(2) Each school should have sanitary inspections by persons with professional training in public health or sanitation.

(3) Schools should help educate parents to the need of vaccinating and immunizing children toward the end of their first year of life.

(4) Schools should arrange for sufficient medical service so that examinations may be made carefully and unhurriedly. Less frequent examinations conducted in a desirable manner can be of

greater value than annual examinations done superficially. Audiometers should be used more widely for testing the hearing. (The Massachusetts School Health Council has prepared recommendations (March 26, 1948) concerning vision and hearing tests in the schools.)

(5) Increased effort should be exerted to have parents present at the health examination of elementary school children.

(6) The desirability and feasibility of encouraging or providing topical applications of sodium fluoride to children's teeth should be investigated.

(7) Broad, comprehensive health courses should be provided in each high school, with classes meeting daily for at least two semesters. Where possible, such classes should be taught by qualified health educators.

(8) A program of pre-employment and periodic health examinations for all school employees should be developed.

*Dental Care*

Recent studies by the American Academy of Pediatrics show public dental services for children operating in all but eight of the Greater Boston communities, with approximately 100,000 dentists' hours per year available to the 360,000 school children of the area. Fifteen communities provide services for preschool children. It is estimated that 340,000 dentists' hours per year are devoted by private practitioners to children under fifteen, with one-fifth of this total available to preschool children. It is difficult to know whether this ratio of public to private dental services is adequate on the public side. Figures of the State Department of Public Health indicate that needs are not being met. Counting of dentists' hours cannot indicate the quality of service and gives only a rough idea of the quantity. The economic status of a community determines to a considerable degree how much of the dental care load should be borne by public agencies and how much can be provided by private practitioners. It may be said that the eight communities with no public dental services at all are substandard.

Development of public dental services in the Area is hampered by two personnel problems: low salary level allowed full-time dentists and the limited supply of dental hygienists. Ten vacancies existed in public agencies during six months of the Survey's field work.

To bring better dental care to more people of Greater Boston:

We Recommend: (1) Restorative dental service carried on by public agencies for elementary school children should be stabilized near the level of presently satisfactory communities, as shown in our full Division Report; and the current neglect of the permanent teeth of high school children should be corrected.

(2) Attention should be given to preventive measures, and surveys of caries prevalence should be carried on to measure progress of the dental program.

(3) Common standards should be developed for public dental services; record forms standardized; and a cooperative consultation service be formed between local and state dental groups.

(A complete list of our recommendations on dental care is contained in our full Report on Health Services.)

*Nutrition*

Fourteen communities, including Boston, comprising 69 percent of the population in the Survey Area, have nutrition services; each community employing one or more nutritionists, at an estimated total annual cost of $75,000. The three principal financing agencies are the Community Fund (which frequently channels its contributions through the Visiting Nurse Associations), the Red Cross, and the local Health Departments. Because of the practice in some nursing agencies to combine expenses for nutrition with other costs, it is impossible to give an accurate figure for the total cost of nutrition services.

We Recommend: (1) Nutrition services should be expanded, with each nutrition service assisted by a nutrition advisory council affiliated with a local health council.

(2) Where possible, the nutrition service should be part of the program of the local health department.

(3) Consultant service should be emphasized and direct service by nutritionists reduced to a minimum.

(A complete list of our recommendations on nutrition is contained in the full Report on Health Services.)

*Boston Health Department*

A detailed and comprehensive study of the Boston Health Department was made in 1948 by the Finance Commission of the City of Boston under authorization of the General Court. That study, when available, will be added to the Survey files in the Research Bureau of the Greater Boston Community Council. For this reason, the activities of the Boston Health Department are treated briefly here. A special statement on the Department's public health nursing program will be found under Public Health Nursing below.

The Health Department is an Executive Department of the City of Boston, directed by a Health Commissioner appointed for a four-year term by the Mayor without confirmation by the City Council. Deputy Commissioners and Division Heads are appointed by the Commissioner from Civil Service lists with the approval of the Mayor and the Budget Department. Many of the organizational aspects and service responsibilities of the Department stem from old and obsolete laws, some dating back more than a century. There is no Board of Health, but an Advisory Board and two consultants have been appointed by the Commissioner. No regular meetings of the Board nor regular staff conferences are held, but policy determination appears to be based on adequate staff discussion.

To render local health service throughout the City, there are eight District Health Units (a building for one more is under construction) and approximately ten sub-stations and clinics in libraries and other public buildings in those areas of the City not served by a District Health Unit.

In 1947 the Health Department spent $1.48 per capita, including federal funds, which compares favorably with other localities, according to the American Public Health Association. In spite of this fact, Departmental salaries are low even though cost of living increases have been granted. A review of expenditures by type of service reveals that there is a relatively low financing of general administration, vital statistics, health education, laboratory work, and nursing. Tuberculosis control, sanitation, and food service receive more than the usually recommended share of the total budget. The services with relatively high expenditures are among those showing the greatest operational weaknesses. Low percentages for nursing and health education are partially explained by low salaries, coupled with existing vacancies in positions for which appropriations are available.

More interdepartmental coordination of services seems advisable, and greater cooperation with the State Department of Public Health would be of benefit in extending the best possible health service to the people of Boston.

A summary of our recommendations, printed in detail in our full Report on Health Services, follows:

We Recommend: (1) General reorganization of the administrative structure of the Health Department of the City of Boston, through amendment of the City Charter, to be undertaken at an early date and with attention given to the following subjects:

a) Creation of a Board of Health.
(This would be an advisory and policy-making body composed of not over five members, representing lay and professional leadership which should meet regularly.)

b) Establishment of the position of Assistant Health Commissioner.

c) Grouping of the Services of the Department into 4 major sections: General Services, Medical Services, Environmental Sanitation, Local Health Units.

d) Changes in the Civil Service law and regulations:

(1) To require adequate training, or, for certain classifications, adequate experience, for eligibility to take examinations for technical positions in the Health Department;

(2) To limit the length of probationary appointment to a reasonable length of time;

(3) To bring the present preference given by State law to veterans (particularly those disabled, who automatically go to the head of the Civil Service list, into conformity with present federal practice (5 percent preference);

(4) To emphasize the responsibility of the Civil Service Commission to provide qualified public servants as well as to protect the rights of public employees;

(5) To permit the recruitment of qualified technical personnel outside of the City and the State.

e) Development of an adequate salary scale.

*Public Health Nursing in Greater Boston*

A total of 566 public health nurses served the people of Greater Boston in 1946. Total cost of such service was $1,566,664 — $775,238 for Boston, and $791,426 for the Metropolitan Area. The nurses were employed by 120 different organizations, as follows: official Health Departments in Boston and

33 other communities; School Systems, Boston and 39 other communities; Visiting Nurse Associations, Boston and 43 other communities; and 2 Welfare Departments outside of Boston. In the Metropolitan Area, 117 separate organizations employed 297 nurses.

In Boston, the expenditure works out to $1.01 per capita, just about what should be spent for ideal service of this kind. For the combined population of the other 54 communities, the expenditure averages $.65 per capita: 18 spending over $1.00 per capita (in five cases over $1.80); but 9 spending less than $.50 per capita (in two cases falling to $.30 and $.32). These are disquieting differences.

The ratio of public health nurses to population is, on the whole, an excellent one. The ratio for a reasonably ideal program should be one nurse for each 2500 population (some authorities say one to 2000). Boston's ratio stands at one nurse to 2900. The average ratio for the 54 other cities and towns is only one to 4100, ranging from one to 697, to one to 7,085.

Aside from the needs of the Boston Visiting Nurse Association, which will be considered later, and those communities which still have a very low ratio of nurses, the need of the entire Area is not for increased funds and personnel but for better organization.

*Nursing Service of the Boston City Health Department*

The largest nursing staff in the Area is employed by the Boston City Health Department. Its program includes health instruction in homes and clinics, for the most part in connection with control of acute communicable diseases and tuberculosis, and with child hygiene; health services to day nurseries and to parochial schools; follow-up of patients with venereal disease, by specialized nurses assigned to the Division of Communicable Disease. Each nurse is responsible for home visiting and services to parochial schools within the district assigned to her.

There is a separate budget for the Public Health Nursing Division of the Health Department, but the Director does not participate in over-all administrative planning or budgeting. Full-time personnel includes the Director, 20 supervisors, and 84 staff nurses. The present number of supervisors is unusually high and can scarcely be justified. The recommended ratio of supervisors to staff is 1 to 8 or 10 staff nurses, including students.

There are only two clerical workers for the entire Division consisting of 105 persons. No clerical workers are available in the district offices and nurses compile district reports. It is wasteful and inefficient to assign professional personnel to work that can be done by workers less highly trained and paid.

The nursing service of the Department is said to be generalized, but the record system is such as to make effective generalized nursing almost impossible.

Most serious is the fact that there is no plan for regular supervision or evaluation of the nurses' work, nor are any special report forms for these activities available. Neither are any specialized nursing consultant services available to the staff. Regular staff education conferences are not planned.

A summary of our recommendations follows:

We Recommend: (1) The public health nursing services of the Boston Health Department should be administered through a separate Section of Public Health Nursing, under Medical Services, with the Nursing Director responsible to the City Health Officer through the Chief of Medical Services.

(2) Steps should be taken to establish the positions of Assistant Director and Educational Director, both of which are appropriate and necessary, and both of which are operating at present without Civil Service recognition; and, in addition, positions for specialized consultants and administrative consultants. Education and experience requirements in accord with those recommended by the NOPHN and the APHA should be adopted for these positions. Education and experience requirements for the present positions of Director, Supervisor and Staff Nurse should be revised to meet those recommended by the NOPHN and the APHA.

(3) The number of generalized nursing supervisors should be determined by the recommended ratio of one supervisor to 8 or 10 staff nurses, including students, a ratio far exceeded in the present set-up.

(4) A clerk should be secured for each District Nursing Office.

(5) A uniform system of records, including family folders and individual patient records, should be adopted.

(6) A program for staff development should be adopted, to include: (a) a plan for regular supervision and evaluation, with suitable record forms; and (b) regularly planned staff conferences related to job mechanics, agency policy, program planning and evaluation of service.

(7) A technical advisory committee to the public health nursing service of the Health Department should be appointed, and consideration should be given to the appointment of a citizen advisory committee. This latter committee should be a sub-committee of the over-all Health

Department Advisory Committee. (See recommendation on this point later in this portion of the Report.)

*Nursing Service of the Boston Public Schools*

A second important part of the public health nursing service of the City of Boston is provided by the School Nursing Division of the Department of School Hygiene under the Boston School System.

The Boston School System serves 202 Elementary and Junior High Schools (with 68,371 pupils); 23 Secondary Schools (with 22,441 pupils); and 9 special schools (with 2,800 pupils). There are 62 nurses serving these schools at present. The School Nursing Division provides services in a ratio of one staff nurse to about 1,119 pupils. When a specialized school nursing plan is followed, it is generally recommended that there should be one nurse for approximately each 1,500 to 2,000 school children.

Nursing services are available to only 74 percent of the total children enrolled in the Boston City Schools.

Nurses' work is evaluated periodically; instruction is given new staff members; supervisors' conferences are held weekly; and the medical director participates in staff conferences from time to time. A manual is available for each staff member; the staff receives in-service training; and members of the Nursing Division meet monthly to prepare monthly reports. Nurses remain in their schools through the school day and make home visits after school.

The school nursing program also is extended to wider educational fields by cooperating with Boston University and schools of nursing in offering field experience to graduate nursing students.

We Recommend: (1) The requirements for future certification for school nurses should be revised to meet those recommended for public health nursing positions. Positions and qualifications should be established for the positions of Supervisor, Assistant Supervisor and Staff Nurse, and these qualifications should apply to all new personnel.

(2) The present school nursing service should be extended to all the pupils in the Boston City Schools, including those special schools and secondary schools not now covered by school nursing service. A ratio of one nurse to about 1500 pupils, which could be covered adequately by the present staff, should be established.

(3) The present nursing functions should be reviewed to assure the most effective use of nursing time. Such activities as classroom talks, compiling of reports, taking children to clinics, and routine classroom inspections should be eliminated. Time should be available for planned nurse-teacher conferences and for working with families by nurses.

*Visiting Nurse Association of Boston*

The Visiting Nurse Association of Boston is one of the outstanding and progressive organizations of its kind in the country. At present, it offers nursing care of the sick in the home and family health instruction to all persons, on a pay, part-pay, or free basis. All available public health nursing for antepartal and postpartal patients is provided through the Visiting Nurse Association. Mothers' clubs are held regularly in 10 districts of the city. In addition, physical therapy services in the home are provided by a supervisor and six qualified physical therapists. Services of 10 nutritionists are also provided. Industrial nursing, which is also offered, is used by a few small industries. In addition to mental hygiene and nutrition consultants, the Association provides, through the supervisor of orthopedic nursing and physical therapy, an advisory service to assist the nurses in giving care to orthopedic patients and in their educational work.

The annual cost of this service is 44 cents per capita, as compared with 35 cents for Health Department nursing and 22 cents for the nursing work of the School System.

Staff requirements for appointment are standard and acceptable. In 1946 the professional staff totalled 116, including specialists and nurses as well as two practical nurses. All receive the advantage of periodic supervision and in-service education from special consultants in mental hygiene, orthopedic nursing, physical therapy, and nutrition.

To meet the needs for nursing care to the sick in their homes, it is estimated that about one nurse to each 5,000 of the population is necessary. Counting the 77 staff nurses, 2 substitute and 2 practical nurses — a total of 81 — the ratio of nurses for nursing care and health supervision of maternal and newborn patients is about 1 to 9,400. Therefore, it is clear that the staff of the V. N. A. is not adequate in numbers for the discharge of its many duties. Furthermore, the V. N. A. carries not only morbidity service, but a considerable volume of maternal and child health work.

This raises a very serious problem — that of the financial support of the V. N. A. Net annual deficits from operations ($25,254 in 1947 after a Fund allotment of $134,000) have been met from capital

funds. It is obvious that the V. N. A. cannot continue to operate on such a basis. Some services have already been curtailed and further sacrifices will be necessary unless more funds are obtained. Yet in terms of needed service, the activities of the organization should be extended, not diminished.

It is not likely that fees from patients and insurance companies can be materially increased. Rates have now been raised to $1.75, which closely approximates the cost of a visit; and of all visits made during 1946 (168,385 to 25,854 patients), 47 percent were paid for by the patients themselves, insurance companies, and other agencies. Some increase in contributions from the Community Fund would seem to be warranted. A study made in 1948 of 154 community chests showed that nursing service agencies received 49.4 percent of their total income from community chests.

The Boston V. N. A. renders nursing service for antepartal, postpartal and newborn patients. Such service has long been generally accepted as the responsibility of the official agency. The V. N. A. should be reimbursed for this service from tax funds.

The Boston V. N. A. also gives nursing service to many recipients of public assistance who are "settled" in Boston and who are Boston's legal responsibility. In one year 20,384 nursing visits were made to OAA and ADC clients of Municipal Boston, at an estimated cost to the V. N. A. of $32,818. It is the approved policy of the State Department of Public Welfare that such costs shall be reimbursed to the voluntary V. N. A. In fact, such reimbursement is made by local public welfare departments in Massachusetts communities other than Boston. Up to this date, however, the Overseers of Public Welfare of Boston, although requested, have not made payments for such nursing services to the V. N. A. Of Visiting Nurse Associations in seven large cities with which comparisons were made, the Boston V. N. A. is the *only one* which receives no income from tax funds.

We Recommend: (1) A cost accounting system should be set up so that the costs of various services rendered by the Visiting Nurse Association of Boston can be segregated — for example, nutrition, physical therapy, preventive services to mothers and infants, services to recipients of public assistance, etc. Separate budgets can be prepared and funds sought for the operation of these specific services.

(2) Until such time as the Boston Health Department is prepared to carry preventive services for expectant mothers, postpartal and newborn patients, currently provided by the Visiting Nurse Association, the Health Department should reimburse the Visiting Nurse Association for the cost of rendering these services.

(3) The City of Boston should reimburse the Visiting Nurse Association for the cost of nursing care services rendered to recipients of public assistance who are the City's legal responsibility.

(4) a. Whereas the nutrition service should be continued, direct service to patients by nutritionists should be reduced to a minimum and should include only special problem cases. Matters requiring general family budgeting should be referred to a family service agency. Efforts should be made to secure special earmarked funds for nutrition service.

b. In order to secure special earmarked funds for physical therapy, approach should be made to the Suffolk County Chapter of the National Foundation for Infantile Paralysis and the Bay State Society for Crippled Children and Adults.

(5) The services of a cancer nursing consultant should be secured. If, at the outset, the full-time services of such a consultant are not needed by the Boston V. N. A., such consultant might be attached to the staff of this agency either on a part-time basis, or on a full-time basis with her services made available to other agencies in the community in a consultant capacity. Funds for the training and employment of such a consultant should be sought from the Massachusetts Branch of the American Cancer Society.

(6) The nursing staff of the Visiting Nurse Association should be substantially increased from the present low ratio of one nurse to 9,000 persons. (For bedside nursing care services alone, the ratio recommended by the National Organization for Public Health Nursing and the American Public Health Association is one nurse to 5,000 persons.)

(7) Industrial nursing service provided to small plants on a part-time basis should be encouraged and the cost of such services borne by the industrial plant receiving the service.

(8) The rheumatic fever program should be continued for the present until it is established on a firm basis, at which time it should be taken over by the Boston Health Department.

*Review of the Public Health Nursing Program in Boston As a Whole*

In Municipal Boston, nurses of the Health Department, the Visiting Nurse Association and the Boston City Schools made a total of 306,590 home visits in 1946. Health Department nurses visited

cases of acute communicable disease and tuberculosis cases and offered health services to infants. V. N. A. nurses visited cases of non-communicable disease and some acute communicable diseases; maternity (antepartal, delivery and postpartal) cases; and gave services to newborn babies, infants, preschool and school children and adults. Boston City School nurses visited only public school children.

Another group of nurses, working for the Catholic Archdiocese, gives nursing service in the home. The Boston Tuberculosis Association employs a nurse for follow-up work with preventorium children.

Analysis of home visits in Municipal Boston shows obvious duplication of services to patients with communicable disease and to infants, preschool and school children receiving health supervision. It is possible that Health Department nurses from the Division of Nursing and others from the Communicable Disease Division may visit the same family. Four nurses, representing four different agencies or divisions of one agency, may appear in the same home on one day. A spot check of 25 families which had received nursing care and health supervision services by the V. N. A. was made to secure data as to the amount of overlapping and duplication of nursing services. The result shows that in one month three of these twenty-five families were visited by nurses from all three agencies. In one family the V. N. A. nurse visited to give maternity service and health supervision; the school nurse visited because of conjunctivitis in a child; and the Health Department nurse visited because of an acute communicable disease. Instances of other serious duplication of visits will be found in our full Report.

Along with duplication, there are serious gaps in the program. These gaps are detailed in our full Report. Existence of duplication on the one hand, and of gaps in service on the other hand, in the public health nursing services to families, is uneconomical and inefficient, and confusing to families. Even more serious is the effect of such a program on the quality of work performed. Public health administrators agree that in large urban centers the best public nursing can be obtained only if there are, at the most, one official agency and one voluntary agency. Some authorities believe it is desirable to develop one combined service, which provides a completely generalized family health program including health supervision and nursing care of the sick.

No program of coordination in this complex field can be undertaken hastily. Success can come only through voluntary cooperation on the part of the agencies concerned, after open-minded study of all the factors in a given local situation. A beginning of such consideration should be made in the City of Boston.

We Recommend: (1) A strong public health nursing committee should be appointed. It would seem desirable for the City Health Commissioner, the Superintendent of Schools, and the Chairman of the Division of Health and Hospitals of the Greater Boston Community Council to join in the official appointment of such a public health nursing committee, which should be a Committee of the Greater Boston Nursing Council. All agencies providing public health nursing or home follow-up for health purposes should be represented. In addition, several persons from the community at large should be on the Committee. The Committee should establish plans and policies for the coordination of the public health nursing service in Boston and publish its recommendations.

(2) A completely generalized nursing demonstration area should be established immediately by the Department of Health, the Visiting Nurse Association, and the Boston School Committee, with the aforementioned Public Health Nursing Committee as the advisory, policy-forming group for this program. The chief objective of this program should be to determine through actual demonstration in a specific area its economies and effectiveness. (Detailed suggestions for setting up this project are contained in our full Report.)

(3) As an ultimate goal, the Department of Health and the Boston School Committee should plan jointly for the provision of nursing services for the school health program as part of the generalized public health nursing program of the Department of Health. This principle of joint services deserves consideration for the total health service program for children of school age.

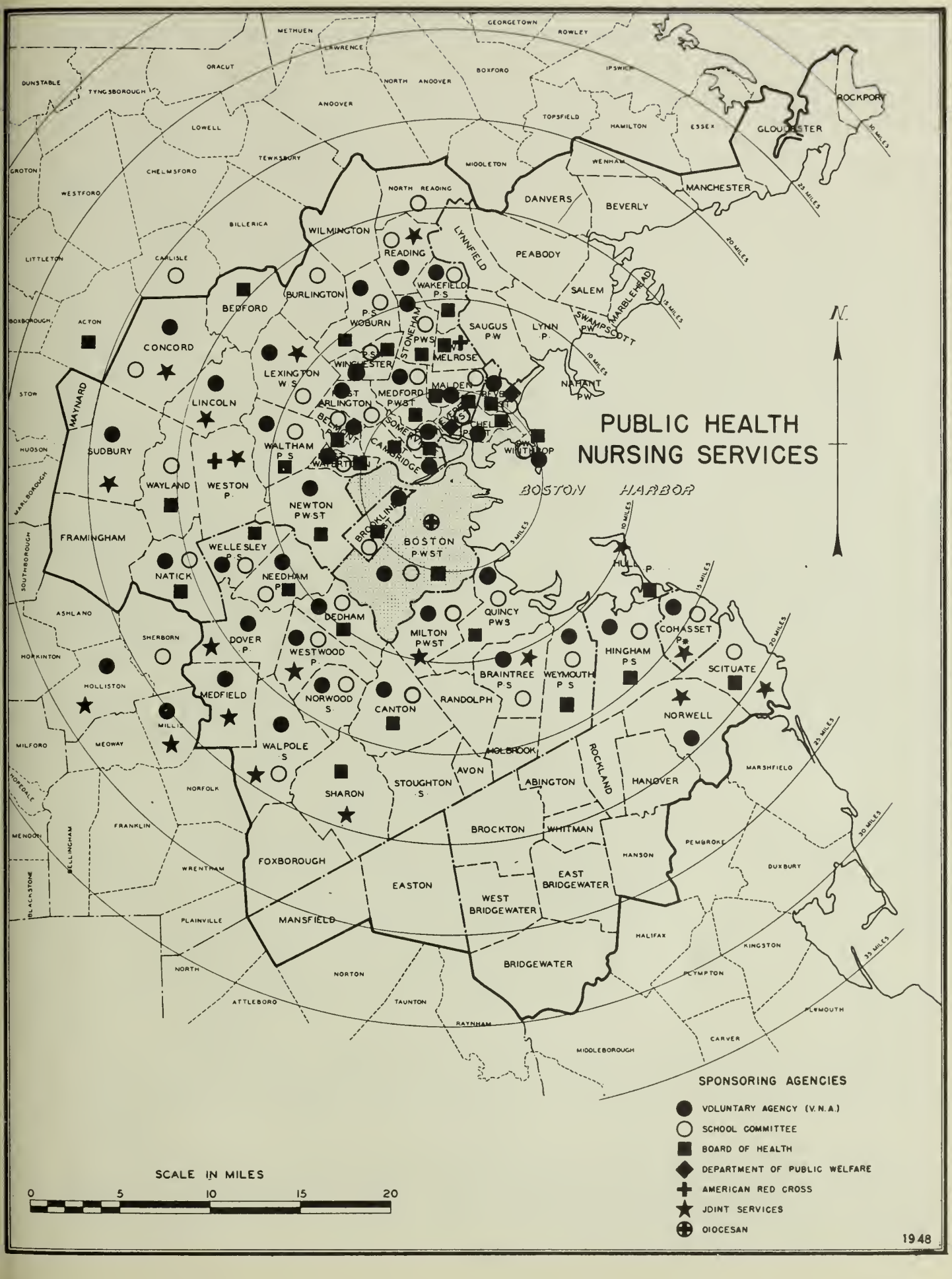
The foregoing recommendations provide broad and comprehensive approaches to the improved structure of public health nursing services in Municipal Boston. Our Report on Health Services, and our specialized Report on Public Health Nursing, contain many more detailed recommendations.

*Public Health Nursing in the Metropolitan Area*

Every one of the communities in the Greater Boston Area has at least *some* public health nursing service.

School nursing and some conventional preventive nursing are provided in all cases from some source; but six towns lack any provision for nursing care of the sick in their homes. School nursing is commonly over-emphasized in proportion to other nursing needs.

There is the greatest duplication of services by different agencies and by specialized nursing services


PUBLIC HEALTH
NURSING SERVICES
N.
BOSTON HARBOR
METHUEN
GEORGETOWN
ROWLEY
LAWRENCE
DUNSTABLE
ORACUT
TYNGSBOROUGH
NORTH ANDOVER
BOXFORD
IPSWICH
ANDOVER
TOPSFIELD
HAMILTON
ESSEX
GLOUCESTER
ROCKPORT
LOWELL
TEWKSBURY
MIDDLETON
WENHAM
GROTON
CHELMSFORD
WESTFORD
NORTH READING
DANVERS
BEVERLY
MANCHESTER
BILLERICA
WILMINGTON
READING
LYNNFIELD
PEABODY
LITTLETON
CARLISLE
WAKEFIELD P.S.
SALEM
MARBLEHEAD
BEDFORD
BURLINGTON
P.S.
WOBURN
STONEHAM
SAUGUS P.W.
LYNN P.
SWAMPSCOTT P.W.
BOXBOROUGH
ACTON
CONCORD
P.S.
WINCHESTER
PWS
MELROSE
NAHANT P.W.
LEXINGTON W.S.
MALDEN
MEDFORD P.W.S.T.
ARLINGTON
MAYNARD
STOW
LINCOLN
BELMONT
SOMERVILLE
CHELSEA
WINTHROP P.W.
WALTHAM P.S.
CAMBRIDGE
WALTHAM
HUDSON
SUDBURY
WAYLAND
WESTON P.
NEWTON P.W.S.T.
BROOKLINE
MARLBOROUGH
FRAMINGHAM
BOSTON P.W.S.T.
HULL P.
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SOUTHBOROUGH
NATICK
NEEDHAM P.
ASHLAND
DEDHAM
QUINCY P.W.S.
COHASSET P.
SHERBORN
DOVER P.
MILTON P.W.S.T.
HINGHAM P.S.
HOPKINTON
WESTWOOD P.
BRAINTREE P.S.
WEYMOUTH P.S.
SCITUATE
HOLLISTON
MEDFIELD
NORWOOD S.
CANTON
RANDOLPH
NORWELL
MILLIS
MILFORD
MEDWAY
WALPOLE S.
HOLBROOK
ROCKLAND
MARSHFIELD
NORFOLK
SHARON
STOUGHTON S.
AVON
ABINGTON
HANOVER
FRANKLIN
BROCKTON
WHITMAN
PEMBROKE
MENDON
BELLINGHAM
HANSON
DUXBURY
WRENTHAM
FOXBOROUGH
EAST BRIDGEWATER
EASTON
WEST BRIDGEWATER
BLACKSTONE
PLAINVILLE
MANSFIELD
HALIFAX
KINGSTON
NORTH
NORTON
BRIDGEWATER
PLYMPTON
ATTLEBORO
TAUNTON
PLYMOUTH
RAYNHAM
CARVER
MIDDLEBOROUGH
10 MILES
15 MILES
20 MILES
25 MILES
30 MILES
35 MILES
SPONSORING AGENCIES
VOLUNTARY AGENCY (V.N.A.)
SCHOOL COMMITTEE
BOARD OF HEALTH
DEPARTMENT OF PUBLIC WELFARE
AMERICAN RED CROSS
JOINT SERVICES
DIOCESAN
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within the same agency. (The insert map throws light on this chaotic situation.) In one community, with 10 full-time nurses and one half-time nurse, six nurses might conceivably visit the same family on a given day. Such a disorganized program involves needless expense through duplication of home visits and through the high cost of services rendered by school nurses to groups of pupils so small that they do not require a full-time nurse. Even more serious is the fact that a high quality of intelligent family nursing is impossible under such specialized programs. In only two areas is there a single complete generalized public health nursing service under either town or V. N. A. auspices.

The qualifications of nurses in many of the smaller areas, the salaries paid to them, and the conditions under which they work, are below reasonable standards. The lack of effective supervision makes this situation more serious.

The financing of public health nursing in these areas is as planless as its organization. Costs properly chargeable to tax funds are, in many communities, being carried by voluntary contributions.

Leadership of the State Department of Health and of the Greater Boston Nursing Council is needed to promote sound programs in the future. All of the 55 towns and cities in the Greater Boston Area are within three of the State Health Department Districts. Since the Department is supported through tax funds, its services belong to the local towns and cities and should be used extensively by them.

All authorities on public health are agreed that efficient, economical and effective nursing is organized for generalized service on a district basis. For small communities, a single public health nursing service can most effectively and economically serve the people on a family basis. It is further agreed that a population of 50,000 is needed to support an adequate program of public health. Therefore, the Greater Boston Nursing Council and other interested groups should work toward having public health nursing services as part of a total health organization which would serve at least 50,000 people.

To improve the organization for public health nursing services in communities of the Metropolitan Area:

We Recommend: (1) In each community having more than one agency providing public health nursing services, careful consideration should be given to the advisability of forming a combination agency, jointly administered and financed by voluntary and official agencies and with all field service rendered by a single group of public health nurses working under qualified supervision; and in each community where only the Public School System employs a nurse, steps should be taken to form a community nursing service to provide all public health nursing services in schools, clinics and homes, including bedside nursing care, under the joint administration of the Board of Health, the Public School System, and a citizens' committee.

(2) In each community a local group representing existing health department nursing, school nursing, voluntary agency nursing, and citizen interest, should be formed to study the local situation and formulate a balanced community nursing program, to assure provision of all public health nursing services in schools, clinics and homes, including nursing care of the sick; to assure joint planning by education and health personnel for school health services; and to assure citizen participation through a citizen's committee.

(3) The Greater Boston Nursing Council should recommend a uniform code of personnel practices for all agencies providing public health nursing services in the Greater Boston Area — i.e., schools, boards of health, and voluntary nursing agencies. A uniform code applicable to such a large and diverse geographical area should establish categories which give equitable consideration to basic differences in population, cost of living, etc.

(4) Whatever the pattern of organization, supervision and staff education should be provided for the nurse working alone as well as all other nurses through —

a) joining together of towns or agencies to provide supervision and staff education; or
b) purchasing supervision from a nearby agency; or
c) requesting frequent itinerant generalized nursing supervision from the State Department of Health.

(5) The local committee suggested under (2) above should make a careful study of sources of local financing; with a view to equitable division of the cost of nursing service and to assure sufficient tax appropriations to maintain at least the so-called preventive services, such as maternal and child health services, including clinics, acute communicable disease and tuberculosis control.

All of these five recommendations can be carried out on a local community level. The attainment of anything approximating ideal conditions will require, however, cooperation among several communities. Of the 54 Metropolitan communities in the Council Area, only 7 have populations of over 50,000; 11 have populations between 20,000 and 50,000. These areas could individually provide themselves

with adequate nursing services. Thirteen communities of 10,000 - 20,000 population and 23 towns with populations under 10,000 cannot do so efficiently, unless they cooperate with each other or with adjoining larger communities.

We Recommend: (6) Provision for integrating and combining public health nursing services of metropolitan communities should be coordinated with plans for the formation of local health unions discussed in the later section of this report dealing with local health organization. In the absence of adequate local health departments, *any* plan for improving public health nursing service can be only partially successful.

(7) As a preliminary step, those persons interested in public health nursing in each of the smaller communities should initiate an intensive study of their local problem with a view toward cooperation with adjacent communities in planning an effective joint health nursing unit, on a pattern similar to that set by Dover, Medfield and Norfolk; and the Greater Boston Nursing Council should request the Massachusetts State Health Department to assign at least one well-qualified public health nurse to the Greater Boston Area to assist in carrying out Recommendations (6) and (7).

*The Household Nursing Association*

The Household Nursing Association conducts one of the 13 approved schools for attendant nurses in the Commonwealth of Massachusetts, 6 of which are located in Greater Boston. The Association is the only one of these schools which receives financial support from the Community Fund. The school maintains high standards and is held in high esteem by the community, but it faces serious financial problems.

Practical nurses in Massachusetts are licensed as attendant nurses. It is generally recognized that trained practical nurses are necessary to supplement the service of professional nurses.

Coordinated community action for the recruiting and training of attendant nurses is essential because of the shortage of practical and professional nurses, the serious problem of facilities for long term illness in an aging population, and the increasing demand for public health and nursing care services.

We Recommend: (1) The Household Nursing Association should continue the vital service it now performs in training nurse attendants.

(2) A joint study should be made by the Greater Boston Nursing Council and the Household Nursing Association to explore means of financing this educational service, which should not be aided permanently by the Community Fund.

(3) Joint studies should also be made, with the added assistance of other interested agencies, to determine the best methods of training nurse attendants with the facilities available in Greater Boston.

*Greater Boston Nursing Council*

The Greater Boston Nursing Council, a quasi-independent organization, has the status of a Section of the Health and Hospital Division of the Greater Boston Community Council. The organization relationship between the two bodies are discussed elsewhere in the Summary Report. Here only its functions, present and recommended, will be considered.

The purposes of the Council are to study community nursing needs, to promote effective measures and facilities to meet those needs, and to interpret the functions of the nurse to the public. The Council participates in a student recruitment program for 29 schools of nursing; carries on public relations with respect to nursing affairs; conducts studies of salaries and of nursing agencies, to assist such agencies and to determine eligibility for admission to the Community Fund; and helps in planning for public health nursing, for field experience for undergraduate nurses, and for developing referral systems between hospital and health agencies to provide for continuous service to patients.

The Council has done good work, but has been limited in program and accomplishment by lack of sufficient staff. We see the Council as possessing great potential value in improving nursing services in Greater Boston.

We Recommend: (1) The Greater Boston Nursing Council's plan for one day observation in the home, by all students in basic nursing schools in Boston, in the company of personnel of one of the three public health nursing agencies, has been in effect for about a year. This plan should be reviewed and strengthened, and the possibility should be explored of using other types of workers in public health whom the student can accompany into the home.

(2) For those schools of nursing in which referral plans between the hospital and a public health nursing agency are operating, and which have a public health nurse faculty member responsible for the integration of the social and health aspects of nursing, additional days of

observation should be arranged from time to time to provide opportunities for students to observe in the home the same patients whom they served in the hospital.

(3) The Greater Boston Nursing Council should take leadership in planning for public health nursing experience for graduate students as well as for basic nursing students.

(4) The Greater Boston Nursing Council should take steps with the public health nursing agencies to determine the costs of all types of student public health nursing field experience, through application of the new cost accounting method being developed by the National Organization for Public Health Nursing; and the Council should take leadership in interpreting the validity of the costs to educational institutions.

(5) The Greater Boston Nursing Council should take leadership in developing and promoting contracts between suitable nursing schools and public nursing agencies; the contract should provide for all types of student field experience and should include the obligations of each contracting party and the coordinating machinery for developing and evaluating the agency service and student experience.

(6) The Greater Boston Nursing Council should take leadership in interpreting the following principles: (a) that priority should be given requests for student field experience to those collegiate programs which have approved programs of study in public health nursing and those which are in the process of securing such approval; (b) that, until such time as other standards have been developed, the recommended ratio of 1 student to 3 staff nurses for an urban area be maintained.

(7) The Greater Boston Nursing Council should vigorously promote the adoption of requirements as recommended by the NOPHN for all types of public health nursing positions in tax-supported and voluntary agencies.

*Mental Health*

Nervous and mental diseases are at the top of the list of major diseases in Greater Boston and in the United States.

The Massachusetts Department of Mental Health is providing institutional treatment and is also helping to give follow-up service for discharged patients, while assisting in the development of preventive psychiatry on a decentralized community basis. Even with the help of federal, state, and voluntary funds, however, Greater Boston has many gaps in mental hygiene resources. A list of such resources is contained in our full Report, with a discussion of the major clinics and other services and their inadequacy to meet the needs of Greater Boston is demonstrated.

The relative functions of the Family Society of Greater Boston and the Boston Visiting Nurse Association need clarification in regard to mental hygiene. Also, it should be borne in mind that the services of skilled case workers can be more widely used for cases of adults and children on waiting lists and for others needing counseling.

Psychiatric service to sick children in Boston is more highly developed than in most localities. Children with less pressing problems who could benefit from psychiatric services, however, lack the benefit of resources, or are kept on long waiting lists, or are not referred because of the general impression there will be long delays. Such facilities should be materially increased, including the development of new units in Greater Boston; but these steps should follow the strengthening of existing resources with the addition of trained and experienced professional staff members.

While there should be more tax-supported mental hygiene services, there is continuing need for private clinics and consulting services to help in the development of new methods and to carry on research, besides providing obviously needed services. More joint conferences between agencies using mental hygiene services and those rendering such services, for periodic review of needs and plans, would facilitate understanding and cooperative action.

In this complex setting, the Massachusetts Society for Mental Hygiene has outlined plans for increased activity and has already made a beginning toward attainment of reasonable goals without becoming deeply involved in treatment operations. It should also become more active in providing opportunities as a forum and a channel of information in cooperation with official groups.

We Recommend: (1) Community Fund and other private support for the Massachusetts Society for Mental Hygiene should be continued and raised to a higher level, simultaneously with the development of a closer working relationship with a strengthened Greater Boston Health Council. The Council should have as a major responsibility the active study and joint planning for more comprehensive and better integrated mental hygiene services in Greater Boston.

(2) There should be more accessible and extensive mental health outpatient clinics and agency consulting facilities for both adults and children. For children, these should be so placed that their services are integrated with the child's daily educational and recreational life.

(3) Both voluntary and official leadership are needed to promote the extension of services for mental health in the program of the State Department of Mental Health.

*Coordination of Health Services on a Regional Basis*

Many of the public health problems of the Metropolitan Area are common problems which can well be met on a regional basis where they cannot be met on a local basis.

For example, the following three categories of health services can best be handled in this way: (1) Service dealing with sanitation problems which transcend community boundaries (milk control, industrial hygiene, mosquito control); (2) activities based on general hospital services dealing with V.D. control, cancer, heart and diabetes diagnosis and treatment, mental hygiene, crippled children's services; and (3) services of specialists in various health fields, who while employed on a regional basis would work through the local health officer.

*"Health Unions"*

By studying the trade areas, hospital facilities, highway communications, and socio-economic homogeneity of the population, we have tentatively grouped communities in the Metropolitan Area into 10 health districts or "Unions," as shown on the accompanying map. The suggested grouping of communities into districts is somewhat arbitrary and is made rather to illustrate possibilities than to be explicit in what might be done. It can be shown that some communities could as profitably be in one health union as another. The point is that such a community should join some "Union" and not continue trying to provide health services independently with inadequate resources.

The 10 "Unions" omit some communities in the Survey Area which can be better served by a trade area *outside* of the section studied. Sudbury, Wayland, Natick, Sherborn and Holliston naturally would receive their health services out of Framingham. Acton and Carlisle should be part of a district including Lowell, and North Reading looks to Lawrence for service.

Our full Report gives in detail our reasons for the groupings here suggested and shown in the insert map. That portion of the full Report should be consulted for those reasons, which will not be repeated here. The case for such "Unions" does not depend on any particular arrangement of communities; but rather on the incontestable fact that many of the communities involved cannot independently provide health services of even minimal adequacy, whereas such a plan as we propose would provide a truly effective health program for the entire Area at a cost no larger than is now being paid for what is in too many places a distinctly sub-standard program.

*Suggested Program Would Cost No More Than Present Program*

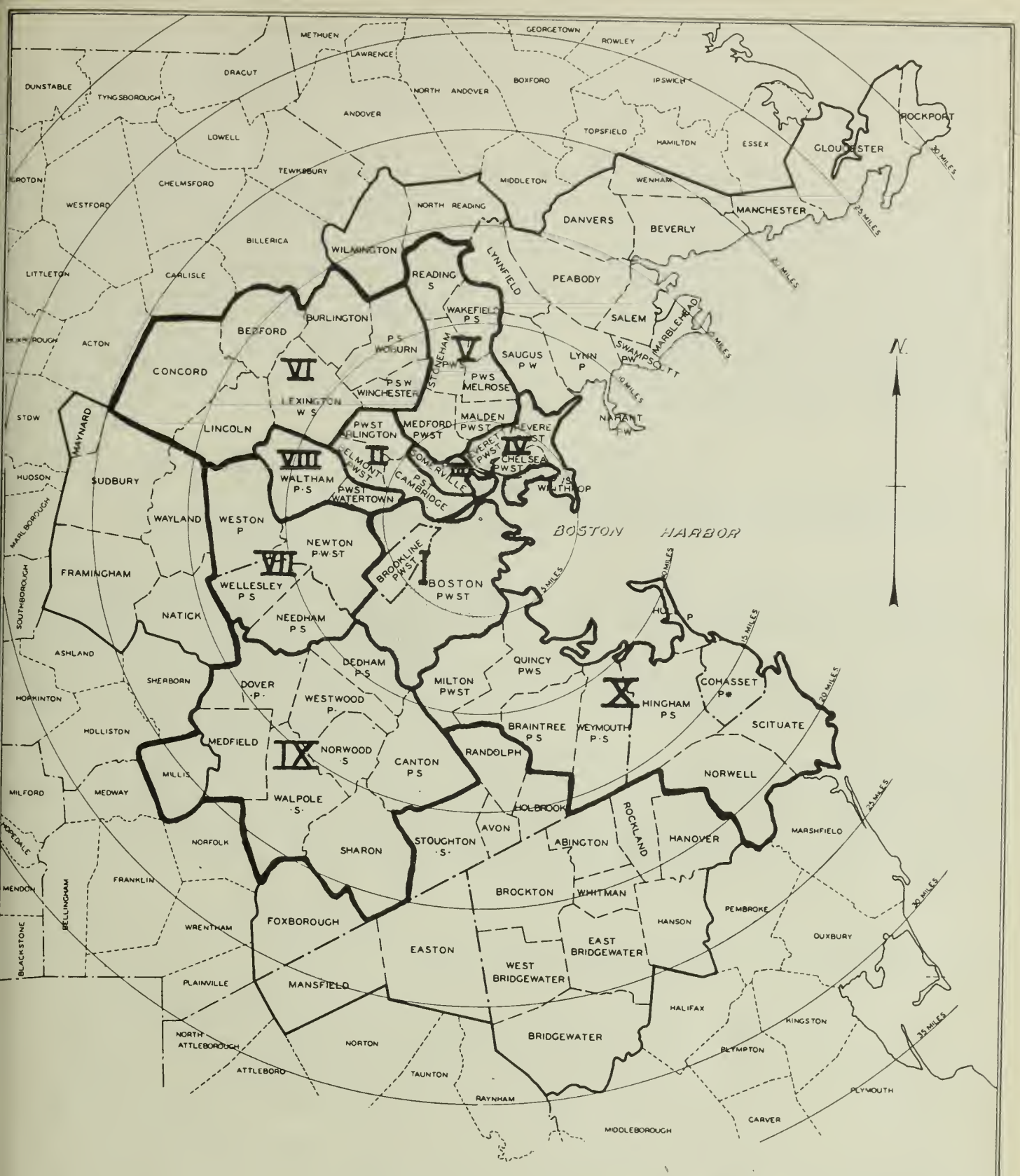
For the Area as a whole, the amount of money spent for public health corresponds to the requirements which are generally recognized as necessary for minimum health services. Although there is great variation in the amount being spent, the present total appropriation is reasonably adequate. Contrary to the usual findings of surveys, better coverage is not entirely dependent on the availability of additional appropriations. With the same dollars now being spent, not only could the minimum services be provided but there could be a profitable expansion into services above the minimum to the benefit of the local people.

*Method of Organization*

The ultimate goal should be one Metropolitan Health Department, with branch offices and neighborhood health centers throughout the Area. There would, however, be resentment to any plan which now proposed making existing health organizations subservient to a strong central agency. The same objection should not be raised to a plan whereby these organizations are given an opportunity to federate into a larger unit for their mutual advantage. A similar arrangement for union of school systems has been in effect in some cases and apparently has worked very well.

Many communities now cooperate in the health field in a rather informal manner and without any over-all planning. The towns of Dover, Medfield and Norfolk use the same nursing organization for public health nursing services. Westwood used the services of the Needham sanitary inspector on a part-time basis. Although the Towns of Wellesley and Weston have independent Boards of Health, they have used the same agent for years. A similar arrangement is in effect in Wakefield, Stoneham and Reading

The outstanding example of inter-community cooperation is the East Middlesex mosquito control




PROPOSED PUBLIC HEALTH UNIONS

IN GREATER BOSTON AREA

2-1-49

project, in which 9 communities pool their resources. It is evident that there has been a partial realization of the inadequacies of the present system.

The "Health Union" organization for the areas described above should consist of a Union Board of Health, a director of health appointed by the Board, and other personnel appointed by the health officer.

*"Union" Board of Health*

The "Union" Board of Health should include at least one representative from each of the communities in its area. In addition to geographic representation, there may be a need for representation on the basis of population, although there are illustrations of practices where such refinement is not necessary. The City of Quincy with a population of 84,000 may require a greater voice in the affairs of the district — without dominating them — than Norwell with a population of 2,200. An equitable representation is possible and a formula has been suggested by the Technical Committee on Local Health Units of the special commission on Public Health established by the 1947 General Court. If a "Union" Board of Health is quite large, provision can be made for an executive committee. The members of the "Union" Boards of Health should be appointed by the local Boards of Health for staggered 3-year terms. In communities without a Board of Health, the "Union" Board member would be appointed by the Mayor or the Chairman of the Board of Selectmen. The functions of the "Union" Board of Health would be:

(1) To appoint the Director of Health for the "Union."
(2) To establish the health policies for the "Union."
(3) To approve the annual budget and its apportionment among participating communities.
(4) To approve Rules and Regulations proposed by the "Union" Health Department.
(5) To hold hearings.

*Director of Health of the "Union"*

The director of health should be appointed by the "Union" Board of Health for an indefinite term. He should not be subject to the Civil Service Laws and regulations, but should be removable for cause. His minimal qualifications should be:

(1) A medical degree from an approved medical school.
(2) Training in public health, with a degree from a recognized school of public health.
(3) At least 2 years of full-time experience in a responsible administrative position in a public health department.
(4) Eligibility for registration to practice medicine in the Commonwealth of Massachusetts.

The director of health should be the executive officer of the department and be responsible for all administrative matters. He should appoint all other personnel of the department within a framework of a merit or Civil Service system. He should be secretary of the "Union" Board and should be responsible for all records and reports of the Board. He should annually make a written report to the Board, together with recommendations for the improvement of the health of the citizens of the "Union" district.

*Legislative Authority and Financing*

A bill to provide legislative authority for the formation and operation of health "Unions," such as those proposed, is to be introduced in the 1949 session of the General Court by the Special Commission on Public Health.

The Health "Unions" could be financed in a manner similar to that provided in Chapter III, Section 27A of the General Laws, in that the "Union" Board "shall estimate the amount of money required, and shall fix and determine the proportion of such costs to be paid by the respective towns" (or cities). Apportionment should be on a per capita basis. The treasurer of one of the communities in the "Union" could be the disbursing agent for the "Union," making payments on vouchers signed by the director of health.

It is expected that within a reasonably short time Federal and State funds will be available for local health work. There is no doubt that one of the conditions for the receipt of such funds will be the performance of certain basic health functions by trained professional personnel. With the proposed grouping of communities, these conditions will be met easily. It is not unreasonable to expect that as much as 1/3 of the local health department budget will come from this source.

Although every effort should be made to encourage communities to improve their health services voluntarily and to meet basic requirements, one cannot think of their continuing indefinitely on the present basis. Too much is at stake in the way of human misery, illness, and death. It would not be

unreasonable to enact legislation requiring that minimum standards as established by the State Health Department be met within a specified number of years. The State has established minimum requirements for roads, for schools, and for other services. Is it rational that basic public health protection should lag behind?

*Metropolitan Health Agency*

In addition to 10 "Health Unions" for the Greater Boston Area as discussed above, some authorities feel the need for a Metropolitan Health Agency to provide 3 types of health services, namely:

(1) Regional sanitation services, such as milk control, mosquito control, and industrial hygiene.
(2) Health programs based on hospital service, such as cancer control, diabetes control, venereal disease control, etc.
(3) The provision of specialists to assist the local health departments.

The organization of the 10 health "Unions" is the first step in the provision of better local health service. Establishment of a Metropolitan Health Agency should not be pushed too rapidly until the "Unions" have been set up. The development of certain health services on a Metropolitan basis is a long-term program which needs to be kept in mind, but which is secondary to the present urgency of better organized local health units. After establishment of the "Unions," the larger regional body would develop to meet the need; the 10 health officers would cooperate on certain programs. There are activities, such as mosquito control and milk control, where the need of cooperative effort is so evident that they would be natural starting points for the Metropolitan body. Once the practice and the framework of a joint undertaking had been established, with good leadership the other programs would follow in due course.

*Summary*

(1) In the Greater Boston Area, disease and death rates do not compare favorably with those of several other sections of the country. This situation is particularly striking when the excellence of medical and hospital facilities is considered.
(2) The present type of local health organization in the smaller communities is not capable of adequately carrying out present day public health programs. The residents of these communities need the same public health protection services as residents in the better urban centers, services comparable in quality to those now being rendered in some of the communities in the area.
(3) The individual Massachusetts town is not, in the majority of cases, a unit of sufficient size for the establishment of good local health departments with trained professional workers. Therefore, We Recommend: Early steps should be taken, including support of proposed legislation to be before the General Court, to secure the grouping of the Greater Boston communities into local public health service "Unions." Such grouping would provide areas of sufficient population and resources to maintain local health departments, with properly trained health teams giving the local residents adequate, economical, and efficient health protection. Furthermore, certain health services can be rendered best on a larger regional basis. The establishment of a Metropolitan Health Agency by the local health unit is proposed as a long-term objective.

*Community Health Education and Planning*

Health education, as employed in this section of the Report, is limited to individual and group guidance or instruction in personal and community hygiene designed to promote better personal and family health and to foster support for, or participation in, community health services.

The health educational services in Greater Boston will be more effective, if the productivity of the few full-time health educators in the Area is increased and opportunities for health education are used to advantage by other workers in the field. Low salary scales at the present time hinder progress, and are a factor in the unwise practice of filling underpaid jobs with untrained people.

Although much has been accomplished by health educators in the Area, the survey reveals a dearth of adequately trained full-time staff members, and — what is equally serious — a lack of any plan for effective collaboration by these few educators.

The Committee on Administrative Practice of the American Public Health Association has set one health educator for each 100,000 population as the standard for effective health education service. In Greater Boston, there is a total of only 15 full-time health educators for a population of two million. Hence, there is an immediate need to recruit and employ more full-time health educators. There is an ever more urgent need to create the means by which those now employed may work together, pool

resources, and enhance the productivity of each by the concerted action of all. Outstanding as have been some examples of individual and agency effort and accomplishment in the Greater Boston Area, our survey reveals the fact that they are only conspicuous highlights in a darkly lit field.

We Recommend: (1) Vacancies for health education personnel in Greater Boston should be filled as soon as possible, and salaries should be elevated for positions in this field for both official and voluntary agencies to be more nearly in line with those of other States.

(2) Consideration should be given, as an activity of the appropriate health council, to the development of neighborhood committees as a bridge between the health departments and residents of the areas concerned, over which traffic in ideas and services may flow in both directions.

Satisfactory public health services also are dependent on effective Greater Boston Health and Hospital Councils. While the Boston Health League has accomplished more than might have been anticipated in the midst of pressing requests and a very small budget and staff, the need for a strong central health council is urgent.

The League, in effect, is the Public Health Section of the Health and Hospitals Division of the Greater Boston Community Council. This Division consists of four Sections: Health, Hospitals, Nursing, and Medical Social Service. Each is a separate entity with responsible executive committees and officers. This, in principle, is a sound plan, but there is need for an over-all planning group to act as a policy-formulating body. At present, there is a Division Executive Committee of two representatives from each of the four Sections. This Executive Committee should be strengthened by the addition of seven members-at-large, chosen by the delegate members of all Sections combined, and should meet with reasonable frequency and attack the problem of over-all health policies in positive and continuing fashion.

All members of the present Executive Committee are professional. In view of the importance of joint study and planning of community problems by both lay and professional groups, the additional seven members should be board members and other lay representatives of the public, with special emphasis on representation of areas outside the City of Boston.

The staff of the Health and Hospital Division is theoretically responsible to the Executive Committee, but its budget presently is split up into thirds and is allotted, somewhat artificially, to the Health, Hospitals and Nursing Sections respectively.

It must be emphasized that a Health Council has enormous responsibilities and opportunities with respect to the stimulation and criticism and support of official health agencies, which receive no Community Fund grants. Such a Council also serves important voluntary agencies outside of the Community Fund. One of the major functions of a Health Council is to provide community leadership of this sort. Its staff must be adequate to cope with problems of this kind.

The present office staff for all four Sections of the Division consists of two professional persons and two secretaries. This staff, competent and devoted to their jobs, can do little more than attempt to meet some of the incidental demands for specific services as they arise. It cannot possibly do the job of continuing over-all planning, which is essential for maximum community efficiency and long range economy.

It is therefore urged that the present frame-work of the Health and Hospitals Division be maintained and strengthened by enlarging and activating its Executive Committee as suggested above; that additional competent personnel be obtained; and that the budget of the Division (exclusive of the Hospital Section) be increased as soon as practicable to approximately $40,000 with the view to obtaining a trained and experienced director who could serve the combined interests of the Health, Nursing, and Hospital Sections.

There is an opportunity in the Metropolitan Area for the operation of local health councils or committees serving the communities covered by the proposed health "Unions." The present local community health councils could be expanded to fit such a pattern. Each of these local health councils would have autonomy and would at the same time be related to the Greater Boston Community Council through having a designated representative on the Health Section of the Health and Hospitals Division of such Council. Already the Metropolitan Area is represented on the Hospital Section and the Nursing Section.

We Recommend: Provision should be made for strengthening the Health and Hospitals Division of the Greater Boston Community Council and supplying it adequately with funds and personnel, as a matter of urgency, in order that joint planning may be undertaken on a more constructive and fruitful basis and cooperative action may be obtained in the economical and efficient advancement of health services in Boston and the neighboring communities.

This recommendation is the most important and basic recommendation in the entire Report on Health Services.

## B. Organized Care of the Sick in Hospitals

*Hospital Bed Needs of Greater Boston Area*

In any appraisal of the hospital bed needs of the Greater Boston Area, consideration should be given to:

(1) Actual number of general and special hospital beds available to the general population in comparison with accepted standards;

(2) Distribution of existing beds throughout the Area;

(3) Physical condition of existing beds; and

(4) Arrangement of hospital facilities in efficient operating units.

(1) There are now in the Greater Boston Area 65 general and special hospitals, including proprietary hospitals but excluding facilities for chronic or long term care and Veterans and other governmental facilities. These institutions provide 9,814 beds (4.93 beds per 1,000 population).*

(2) There is naturally an uneven distribution of hospital beds within the Area. Eighty percent of existing beds, however, are within a 5-mile radius of the center of Boston.

(3) Forty percent of existing beds are in buildings constructed before 1915. Another forty percent of beds are in buildings constructed since 1925. Excluding proprietary and a few other hospitals not reporting, existing bed facilities may be summarized thus:

| | |
|---|---|
| In hospitals that are reasonably modern, with good design and arrangement, and that do not have an appreciable degree of old construction (14.5% of total beds) ..... | 1,330 beds |
| In hospitals with majority of space reasonably modern, but with 10-30 percent old and in need of replacement and modernization (51.2% of total beds) ..... | 4,686 beds |
| In hospitals whose buildings are a mixture of new and old, in which the older structures form a substantial part (18.9% of total beds) ..... | 1,732 beds |
| In hospitals with greater part of their buildings very old and with hardly enough new or modern construction to tie them necessarily to their present location when the time comes for rebuilding (10.3% of total beds) ..... | 947 beds |
| Information not available (5.1% of total beds) ..... | 465 beds |

The factor of obsolescence is important. Within the next decade an effort should be made to modernize or replace buildings with a total of approximately 2,200 beds.

(4) Except in special circumstances, it is difficult to justify the existence of small hospitals in an urban area. Larger hospitals average higher occupancy than smaller hospitals and are better able to provide necessary specialized personnel and facilities. Over 30 percent of the general and special beds in Greater Boston are in hospitals of less than 200 beds. Nine hospitals within a 5-mile radius of the center of Boston, and 10 hospitals outside this zone, have less than 100 beds.

The United States Public Health Service has used a ratio of 4.5 beds per 1,000 population in estimating the "general and special" bed needs of an average urban area. A city which is a center of medical education, however, must meet a hospital demand beyond this percentage of beds. Boston is, of course, one of the world's great centers for medical education. In October, 1947, the Division of Hospital Survey and Construction, Massachusetts Department of Public Health, estimated the bed needs of the Greater Boston Area at a figure calling for 6.3 beds per 1,000 present population and 5.8 beds per 1,000 estimated population in 1955. Also in 1947, the Commission on Medical Care proposed a method of computing bed needs that worked out to a ratio of 5 beds per 1,000 population.

In considering all these and other pertinent factors, we think a ratio of 5.5 beds per 1,000 population is a reasonable one for Greater Boston. On this basis there is a present need for approximately 1,100 additional beds and an estimated need in 1955 of approximately 1,400 more beds than are now available.

New construction under way or projected will add 1,418 beds within the next five years and provide also for the replacement of approximately 600 beds. It is evident, therefore, that the need for additional hospital beds on a per capita basis is within sight of being met. The main problems of hospital construction are concerned with the replacement or modernization of obsolete hospital buildings.

(In making the above calculations, consideration was given to the existence of the following facilities in Veterans and other governmental hospitals: Murphy General Hospital (Waltham); U. S. Marine Hospital (Brighton); U. S. Naval Hospital (Chelsea); U. S. Veterans' Administration hospitals at Bedford,

*In addition, the Area's 5 dispensaries and 15 hospitals with out-patient departments handle about 1,200,000 out-patient visits a year (excluding X-ray, E-K-G, Basal Metabolism and laboratory visits).

Framingham, and West Roxbury; and also of the fact that a Veterans' Administration Hospital of 1,000 beds for general medical and surgical care is planned for location within the Area.)

In view of the foregoing:

We Recommend: (1) Plans for the development of hospital facilities in the Greater Boston Area should envisage the addition of approximately 1,100 beds within the near future, and a total of approximately 1,400 additional beds to meet the estimated needs in 1955. Further, consideration should be given to the need for modernization or replacement of existing, but obsolete, buildings which contain approximately 2,200 beds.

(2) In any planning for the improvement and expansion of hospital facilities within the Area, consideration should be given to the possibility of consolidation of smaller hospital units.

(3) A Committee on Hospital Planning should be established as soon as possible as an instrument of the Hospital Council; and this Committee should endeavor to coordinate all plans for capital fund-raising and for hospital construction and expansion within the Area with a view to avoidance of duplication of facilities and effort.

Some discussions have taken place among hospitals in the Greater Boston Area of the possibility of merging service departments of proximal institutions. Further consideration should be given to the coordination of laboratory facilities among smaller hospitals within an Area. We think joint laundry operations would be possible for certain institutions. We believe also that there are possibilities for joint purchase, storage, and issuance among hospitals which are adjacent to each other.

We Recommend: (4) Attention should be directed to the feasibility of merger of laundry facilities among selected hospitals in the Boston area and to coordination of other service departments where an increase of proficiency may be obtained.

*Financial Experience of Hospitals*

The present financial condition of the Boston Hospitals is of vital importance to the whole community. Because the Community Fund participates in the financial support of many Area hospitals, trends in hospital income and expense bear directly on the total Community Fund allotment to hospitals.

The following table shows, for 27 general and special hospitals in the Area, the extent to which during the last decade costs have risen more rapidly than income:

| | 1938 | 1947 | Increase | % |
|---|---|---|---|---|
| Average patient day cost | $8.64 | $17.56 | $8.92 | 103 |
| Average patient day income | $8.54 | $17.18 | $8.64 | 101 |
| Total patient cost | $9,358,974.00 | $24,120,905.00 | $14,761,931.00 | 158 |
| Total patient income | $9,250,918.00 | $23,594,554.00 | $14,343,636.00 | 155 |

During the period, there was an increase of 37% in patient admissions and of 26% in patient days.

Of the 27 hospitals studied, 19 have been receiving aid from the Community Fund. In 1945, 1946, and 1947 these 19 hospitals showed an excess of expense over income, including Community Fund allotments, while the eight hospitals which received no Community Fund monies enjoyed an excess of income over expenses every year from 1938 through 1947.

Analysis of sources of income in the hospitals over the ten year period reveals the increasing importance of the income obtained directly from patients and relative decreases in percentage of total income received from endowment and from the Community Fund. While the Community Fund contribution to the 19 hospitals increased from $791,545 in 1938 to $1,274,113 in 1947, an increase of $482,568*, the percentage of the Community Fund payments to total income dropped from 9.77 to 6.42. Similarly, the percentage of the endowment income to total income dropped from 15.04 to 9.97, even though the total endowment income rose $750,000 during this period. It is apparent that revenue from patients bears an increasing proportion of the increased cost of hospital care. Hospitals must depend *primarily* on patients, or through Blue Cross or other agencies, for payment of the cost of Hospital care.

A study of 17 hospitals in Greater Boston reveals that their aggregate capital funds have increased from $26,500,000 in 1936 to $37,240,000 in 1946 (unrestricted funds included therein having increased from $9,600,000 to $12,277,000). During this same period hospital operating costs rose over 100%. While the *composite* financial picture of Greater Boston Hospitals today may appear to be sound, this is not true of many individual institutions. Particular concern must be expressed for those institutions which

*These figures do not reflect the fact that, due to shrinkage in the purchasing power of the dollar, the enhanced Fund allotments of 1947 actually could buy less than the smaller Fund allotments of 1938.

traditionally have cared for a large number of ward patients who are unable to pay the full cost of their hospital care and for which assistance has been required from the Community Fund.

These 19 hospitals had combined net deficits in eight of the years 1938-1947 inclusive, ranging from a low of $160.249 in 1940 to a high of $1,081,663 in 1946. And these net deficits were *after* taking into account Community Fund allotments. During the ten year period the combined "operating deficit" of these hospitals (difference between hospital expense and patient income) totalled $35,451,184. This sum represents their charitable contribution during the decade to the needy sick of Greater Boston. Even after their annual operating deficits have been reduced by endowment income, by Community Fund allotments ($9.977.415 for the 10 year period), and by miscellaneous income (donations, etc.), there still remained a *net deficit* for these 19 hospitals of $2,934,881 for the period 1938-1947 inclusive. This deficit has had to be met by the use of capital funds. Without Community Fund aid, the plight of these hospitals, and of the needy sick cared for by them, would have been indeed desperate.

The reputation of Boston as a medical center has depended largely upon these Community Fund Hospitals which have the greatest financial difficulties today. Adequate payment by third parties, such as Blue Cross, the Industrial Accident Board, and the City and State Welfare Departments, is necessary to maintain the financial stability of these hospitals for the benefit of whole community.

*Statistical Experience of Hospitals*

Analysis of the past ten years' hospitalization experience of 27 general and special hospitals shows an increase from 1,083,426 to 1,373,334 patient days — an increase of 289,908 (26 percent). During this period the beds increased from 4,953 to 5,116 — an increase of 163 (3.3 percent).

The percentage occupancy of these 27 hospitals increased from 60 percent in 1938 to 73.5 percent in 1947.

The admissions in these hospitals increased from 92,899 to 127,614 — an increase of 34,715 or 37 percent.

The average patient day stay decreased from 11.6 to 10.8 during the same period.

It is unfortunate that returns could not be obtained from all the hospitals in the Area; but the figures of the 27 hospitals used in the computations above are representative of the hospitals in the Greater Boston Area.

The trend of hospitalization in the three classifications of ward, semi-private, and private patients could not be obtained, because the majority of hospitals do not keep an accurate breakdown of these three categories and most of the reported figures of ward patients include ward private patients. There appears to be a trend toward an increase in the percentage of private and semi-private patients and a decrease in the percentage of ward patients, but it is not possible to establish this until more accurate and uniform statistical reports are available.

Analysis of the past ten years' out-patient visits at seven hospitals and the Boston Dispensary shows a decline from 1,195,300 total visits in 1940 to 781,876 visits in 1945, a drop of 34.6 percent. The total out-patient visits for 1947 was 812,389, an increase of 4.0 percent over 1945.

*Hospital Charges*

We studied the room rates for private, semi-private, private ward and ward accommodations in the hospitals of the Greater Boston area, and the average per diem charge for ancillary services, to make possible a comparison of the total per diem charges with the costs of providing the service.

(i) There is a lack of uniformity in the charges of Greater Boston hospitals for room and board in the various service classifications and the same lack of uniformity obtains in the average per diem charges for ancillary services.

(ii) The total charge for room, board, and ancillary services for private and semi-private patients equals or is in excess of the cost of providing the hospital service.

(iii) In the majority of hospitals, ward charges are far less than the cost of providing the service. Many of the institutions have markedly increased their ward charges within recent years, but disparity between standard rates of charge and actual cost still exists.

Several of the Boston hospitals continue the practice of billing patients or third parties at an "adjusted rate" rather than for the full established charge for the accommodation provided. Payment of such bill in full by the patient or the third party creates an impression that the complete cost of the service provided, rather than only a part, has been paid. If the cost of ward care is $10.00 and the amount reimbursed by a

public agency for care of a client is only $6.00, the hospital bill should indicate a charge of $10.00, with an allowance of $4.00. Under such a method of billing, the true cost is clarified and the amount of the hospital's contribution is obvious.

A three-month study by Massachusetts General, Peter Bent Brigham, Beth Israel, Massachusetts Memorial, and Children's Hospitals, shows that the main loss in these institutions results from the expense of caring for ward patients:

(1) Loss through receiving a fixed rate of reimbursement from public welfare departments which is below both cost and charges;

(2) Loss through fixing rate of charge for ward care below the actual cost of such care.

If hospitals adopt the principle of setting ward patient rates approximately at cost and of adjusting the rate to the ability of the patient to pay, the hospital is enabled to collect from the patient up to his ability to pay, the patient observes from the adjustment the extent of free service he is receiving, and the public and paying agencies obtain a true picture of the cost of the service which the hospital is providing. Therefore:

We Recommend: (5) Hospitals should adjust their rates, when necessary, for room and board, ancillary services, and out-patient services, to insure that for no type of service shall the total charges be less than the cost of rendering the service.

(6) Ward and out-patient rates should be fixed approximately at cost, regardless of the patient's ability to pay; and allowances should be made to those ward and out-patient patients who are unable to pay the full ward or out-patient rate. Under no circumstances should the rate for a patient, whether in a ward or not, to whom a physician is charging a professional fee, be less than the cost of providing the hospital service.

(7) Hospitals should bill their full rates to all paying agencies, indicating, where necessary, the allowance which is being made to meet the difference between cost and payment.

*The Purchase of Hospital Care by Governmental Agencies*

A major reason for the financial problems facing many of the voluntary Boston hospitals today is the policy of public agencies in reimbursing for hospital care of the medically indigent. Our full Hospital Division Report devotes four pages to an analysis of the various different types of governmental reimbursement that obtain today. Such reimbursement for the care of patients that are admittedly the responsibility of a town, a city, or the State can be characterized only as variable, inconsistent, and inadequate. Hospitals must deal with at least five State agencies and with a separate welfare agency for each community. Not only do hospitals receive varying rates from the different State and local agencies, but the same State agency may pay a different rate for the various categories of its clients.

Without detailed elaboration, a mere catalogue of the public agencies with which the hospitals deal reveals a most confusing welter, which is further enhanced by the varying rates of reimbursement for varying types of services (almost without exception at much less than cost):

State Department of Public Health: Emergency Maternal and Infant Care Program; Crippled Children; Pediatric Survey; Chronic Rheumatism; Communicable Diseases; Tuberculosis Surgery; Venereal Disease; Cancer Control.

State Department of Public Welfare: Old Age Assistance; Aid to Dependent Children; General Relief ("unsettled").

State Department of Education: Vocational Rehabilitation.

State Veterans' Aid.

State Soldiers' and Sailors' Relief.

State Department of Mental Health.

State Department of Correction.

Division of Child Guardianship.

State Industrial Accident Board.

Premature Care.

55 City and Town Welfare Departments: public assistance clients in all categories.

The City of Boston, through appropriations to the City Hospital, provides for the cost of care at that Hospital of ADC and general relief patients. In the case of old age assistance cases, the State pays a

statutory rate of $8.00 per day to the patient, after some delay; and a voluntary hospital which has cared for the aged patient must try to collect its bill from him, often finding that the money has already been spent for other necessary things. The City of Boston pays nothing to voluntary hospitals for the care of Boston general relief patients, except for emergency or accident cases (where a part of the cost is paid).

The City of Boston and the State Welfare Department have certain problems which must be appreciated in regard to their payment for hospital care. In several of the large teaching hospitals, teaching or research interest and chronicity of illness may determine the admission of a patient to the voluntary hospital and the "ordinary" case may be diverted to the municipal institutions. The State receives a percentage of reimbursement for hospital care of ADC and OAA patients from the Federal Government only if money is paid directly to the patient rather than to the hospital.

Hospitals have an additional problem in regard to welfare and indigent patients. Not only is State and city reimbursement to hospitals far below cost for the patients for which the State and city have accepted responsibility, but city and town standards for accepting responsibility are extremely variable. Even if the city or State were agreeable to paying to the hospitals their per diem cost, the patients and the hospitals would still be at a marked disadvantage because varying relief standards prevent deserving patients from qualifying for public relief.

Practices and policies vary greatly throughout the Greater Boston Area. Some towns are very strict in eligibility standards for relief. A few towns readily recognize the problem of "medical indigence" and are willing to accept the premise that a family may be normally self-supporting, but that the expense of a long illness cannot be met. These towns will then accept financial responsibility for the hospital and medical care without forcing the patient to sacrifice all his savings and life insurance and mortgage or sell all his property.

A major advance has been made in the principle of payment for hospital care by third parties in the recent (November, 1948) decision of the Industrial Accident Board of the State of Massachusetts that "effective December 1, 1948, . . . for hospital services under the Workmen's Compensation Law, . . . each hospital shall receive as payment for all its charges and services the per diem, all-inclusive in-patient cost which said hospital has certified to the Department of Public Health . . . and which has been approved by said Department." The Board is to be congratulated upon this action, which should serve as a pattern to other public agencies in this and other States.

A study was made during three months of 1948 relative to the cost to four large Boston voluntary hospitals of caring for patients in all categories for whom governmental agencies were responsible. Projecting for a year on the basis of such three-month figures, it is indicated that these four hospitals alone were sustaining for such care an annual loss at the rate of $350,000.

We Recommend: (8) Municipal and State agencies should pay the full cost of in-patient and out-patient services furnished by voluntary hospitals and dispensaries to patients in all categories of public assistance for whom such agencies are responsible.

(9) Welfare payments for hospital and dispensary care should be made directly to the hospitals and dispensaries rather than indirectly through the client, to the extent possible without loss of federal or state reimbursement. Efforts now being made to modify present restrictions in this respect should be continued.

(10) Efforts should be made to achieve uniformity of payment for welfare patients and for the development of a standard method of determining eligibility, and the basic budgets and policies as outlined by the American Public Welfare Association should be used as a guide.

(11) The City of Boston, in recognition of the vital role of the voluntary general hospitals in meeting the health and hospital needs of the City and in order to maintain unimpaired this necessary service, should undertake at once to pay to voluntary hospitals and dispensaries for in-patient and out-patient services furnished by them to patients in all categories of public assistance for whom the City is responsible.

*Massachusetts Hospital Service (Blue Cross)*

The type of Blue Cross contract most in use today provides an indemnity to the hospital of $7.00 a day towards the charge for room and board and a service payment of $4.25, $3.50 or $2.50 for ancillary services, depending upon the rating of the hospital. This contract appears to be the most satisfactory compromise which could be effected during a period of rising hospital costs. We believe, however, that payment of the complete cost of the care of the semi-private patient is more desirable, and that any deviation from the "service basis" weakens the Blue Cross concept.

A question should be raised as to the equity and wisdom of the arbitrary payment of $4.25, $3.50 or $2.50 for ancillary services. We suggest that Blue Cross should adjust its payments to the cost of these services which its subscribers receive. It is doubtful whether any general hospital can provide for even $4.25 a day, the necessary ancillary services outlined in the Blue Cross contract. The net result of the existing system is to encourage hospitals to take advantage of the exceptions in the Blue Cross contract and remove hospital services such as X-ray, physiotherapy, anesthesia, laboratory, from the benefits provided.

If it is the intention of the Blue Cross to provide necessary X-ray, laboratory and anesthesia services, it should be recognized that complete services cost more than incomplete services. If the Blue Cross Plan wants complete services included, the rate of reimbursement should be sufficient to pay the hospital adequately for the cost, including the service of radiologists, pathologists and anesthetists.

The Blue Cross also has outstanding a "ward contract," which covers approximately 10% of its subscribers. Under this contract, a hospital is paid $6.50 per diem but may charge the subscriber additional amounts up to a total bill of $10.00 a day during the first 30 days of hospital care. The hospital may also charge further, if the subscriber's income exceeds specified amounts. This contract is not popular with the subscriber. The use of a "means test" reduces it frequently to an indemnity contract.

The principle of payment of cost, whether it be for the entire hospital care or for segments such as the ancillary services, is a sound one for Blue Cross and the hospitals to follow. As pointed out in the discussion of Accounting and Statistics, there are comparatively few hospitals which are prepared to give detailed cost analyses from which Blue Cross reimbursement may be calculated. However, there are enough statistics to develop interim payments to the hospitals based upon costs, and hospitals with the aid of the Hospital Council, the State Hospital Association, and Blue Cross can, within a comparatively short time, produce adequate cost figures.

> We Recommend: (12) The Massachusetts Hospital Service should abandon the "Ward Plan" contract and concentrate upon the more important program covering the majority of its subscribers.
>
> (13) The Massachusetts Hospital Service should continue the present combination indemnity-service program; but, as soon as possible, adjustments should be made in premium rates to enable payment on a service basis for the entire cost of hospital service.
>
> (14) The Massachusetts Hospital Service should review the present program for payment of arbitrary amounts for ancillary services and develop a contract based upon payment of cost for such services.

*Accounting and Statistics*

Hospitals in Greater Boston are fortunate in that a standard chart of accounts and statistics has been developed, based upon that in use by the United Hospital Fund of New York City, and approved by the Greater Boston Community Fund. Unfortunately, comparatively few hospitals in the Area have adopted this system of accounting, and even these hospitals have done little to determine whether their practices and interpretations are comparable.

The actual fact is that most hospitals in Greater Boston, like others in the State of Massachusetts, do not have sufficient detailed statistical and financial data on which to base accurate statements in the current discussions on third party payment of cost. Boston and Massachusetts hospitals will be unable to convince either the municipal or State authorities or any other third party to pay hospitals adequately for the care rendered until the hospitals are able to present statistical and financial reports which can be understood, compared, and defended. It is also obvious that adequate administrative controls cannot be effected in the absence of standard accounting and statistical systems.

> We Recommend: (15) A standard manual of statistical and accounting method should be prepared by the Hospital Council; all member hospitals should participate in a system of periodic cost analyses; and these analyses should be audited and assembled by the Hospital Council.

*The Hospital Council*

The Hospital Council of Boston has been handicapped by inadequate financial support, incomplete hospital representation, and by the fact that hospital trustees have not participated in its activities. The responsibility of the Executive Secretary has been divided between the Health Council, the Nursing Council, the Section on Medical Social Work of the Greater Boston Community Council, and the Hospital Council.

It is unnecessary to emphasize today the advantages of a strong, well-organized Hospital Council. The existing councils of such cities as Cleveland, Philadelphia, Rochester, and New York, and such regional

organizations as those in Connecticut, Western New York, Pennsylvania and New Jersey, have fully demonstrated their value. Not only are the member hospitals enabled to achieve unity in presenting their problems to the public, to Blue Cross, and to governmental agencies, but the mutual advantages obtained through exchange of ideas, experience and advice are of inestimable value.

The basic principles upon which the reorganization of the Hospital Council of Boston should be based are as follows:

(1) *Representation* from all eligible hospitals in the Area without regard to their relationship to the Community Fund.

(2) *A Council* made up of trustees and administrators from each hospital, and a governing body representing both the trustee and the administrative groups.

(3) *An Executive Secretary* who should be trained, experienced, full-time, and receive an adequate salary.

(4) *Financial Support* by dues from hospital members, by Community Fund appropriation, and (if possible) by Blue Cross subsidy.

The proposed reorganization of the Massachusetts Hospital Association will naturally suggest some method of joint financial support. It is recommended that the reorganization of the State Association, independently of the Hospital Council of Boston, proceed at once. The advantages of a close working relationship with the State Association are obvious. It is suggested that the State Association secretariat share office space with that of the Hospital Council. We recommend that, within the proposed Community Service Federation of Greater Boston, the Hospital Council be one of three major units of the Health and Hospital Division (The Health Council and the Nursing Council being the others), and that the duties of chief executive of at least two of these four bodies be combined in one position.

It must be emphasized, however, that the many problems peculiar to the Hospital Council are of such importance and magnitude that an unusual degree of freedom and autonomy should be permitted and exercised by the Hospital Council. It is important that, for purposes of planning, a close relationship be maintained with the Health Council through the Health and Hospital Division of the proposed Community Service Federation. It is suggested, therefore, that there be adequate representation from the governing body of the Hospital Council on the Executive Committee of the Health and Hospital Division, and that this representation include both trustee and administrative members. It is presumed that similar representation will be carried from the Executive Committee of the Health and Hospital Division to the Board of the proposed Community Service Federation. The Executive Secretary of the reorganized Hospital Council should be appointed by its Board of Directors in consultation with the Executive Director of the Federation.

A suggested set of By-Laws for a reorganized and strengthened Hospital Council is included in the full Report of the Hospital Division.

We Recommend: (16) The Hospital Council should be reorganized at once as a section of the Health and Hospital Division of the proposed Community Service Federation of Greater Boston; representation should include both trustees and administrators of member hospitals; an experienced full-time executive staff should be provided; and financial support should be furnished by a dues or tax system on member hospitals, with a matching amount of allotment from the proposed Federation and the Massachusetts Hospital Service.

(17) The Section on Medical Social Work of the present Health and Hospitals Division of the Greater Boston Community Fund should be transferred to the Family and Child Care Division of the proposed Community Service Federation.

(18) The present Nursing Council should be a Section of the Health and Hospital Division of the proposed Community Service Federation.

(19) A set of By-Laws should be drawn for a reorganized Hospital Council of Greater Boston, along the lines suggested in the Hospital Division Report.

*Proposed Method of Determining Greater Boston Community Fund Allotments to Hospitals*

The Greater Boston Community Fund now makes its allotments to hospitals on the basis of annual operating deficits, with little or no relation to the residence of patients or to the number of units of service given to eligible indigent patients.

It is anticipated that governmental agencies will increasingly recognize that hospital care is a commodity as important and as necessary as the food, shelter and clothing which they purchase for their clients or beneficiaries. As this principle is accepted, and as hospital care in voluntary hospitals is purchased on a

cost basis by governmental agencies, there should be complementary decrease in need for Community Fund allotments to voluntary hospitals.

In any event, it is desirable that allotment of Community Fund monies to hospitals be based on a measurable unit of service. To this end our Recommendation 20 is made. Because of the necessity of including explicit definitions and of the highly technical terms used in describing the new formula — which covers many pages — Recommendation 20 is not reproduced here. It can be found in our full Hospital Report. It outlines a formula for deriving comparable, measurable "units of community service" rendered by all participating hospitals to all ward, out-patient, and emergency department patients; for determining the cost of such service and the income received therefrom for each hospital, and hence the loss suffered by each hospital in rendering such service; and for determining the number of such units for which each hospital should be reimbursed by the Community Fund (within the total amount of Fund monies allocated to hospitals).

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*The Executive Committee of the Survey accepted Recommendation 20, subject to the following proviso: "Recommendation 20 proposes that the Greater Boston Community Fund adopt a method of determining Community Fund allotments on the basis of measurable units of service to replace the present system of subsidy towards net deficits. The Executive Committee recognizes the validity of the principle which underlies the new method. Because of the new method's novelty and difficulty, and of its various aspects which have not yet been fully worked out (as the Report itself indicates), the Executive Committee believes that the new method cannot be fairly judged or made operative until: (1) there has been made a study of the results of its application to participating hospitals and dispensaries over a period of several years, including 1948, on the basis of the actual figures for such agencies for said years; and (2) the Hospital Council and the Central Budget Committee have, against the background of such a study, worked out in detail all aspects of the new method. The Survey Divisional Staff are in agreement with this position. The Executive Committee believes that, when the action referred to has been taken, a determination should be made by the Hospital Council and the Central Budget Committee as to whether Recommendation 20 provides a fair and operable method for carrying into effect the principle of determining allotments on the basis of measurable units of service."*

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*Chronic Care*

Facilities for chronic and convalescent care consist of 1,307 hospital beds in nine institutions in the Greater Boston Area. In addition, there are 3,425 beds in the Tewksbury State Hospital which is outside the Area but which accepts some patients within the Area. There are also about 1,500 beds in registered nursing homes, most of which care primarily for the aged and give only custodial care. (Facilities for chronic care in Veterans Hospitals are excluded from these figures.)

It was surprising to note that the occupancy rates in the chronic disease hospitals have been somewhat low. Of the 1,307 hospital beds for chronic and convalescent care, 250 or 19% are in four institutions for the care of children. These institutions seem to have the lowest occupancy rates.

In addition to these beds in institutions restricting their services to chronic and convalescent care, there is a considerable number of beds in general and special hospitals which are being used for patients with chronic illness. Information was not made available by municipal hospitals of the number of chronic patients cared for; but the 1,300 beds in chronic disease hospitals, 100 beds in general hospitals and 1,500 beds in nursing homes indicate a total of at least 2,900 beds available for long term care.

It is difficult to measure with any accuracy the chronic bed needs of a community, but it has been suggested that 2 beds per 1,000 population are necessary for chronic care and it is anticipated that the desirable ratio will soon be 3 beds per 1,000 population. Under this formula, approximately 4,000 such beds would be required for the Greater Boston Area. Even if all nursing home beds are included, there appears, therefore, to be a deficit in Greater Boston of over 1,000 beds for the care of chronic patients.

Long Island Hospital has approximately one thousand beds, of which about five hundred are designated for the care of "chronic" patients and the remainder for "custodial" patients. It has been proposed that this institution be developed as a modern chronic disease hospital, but the difficulties of transportation and of general accessibility do not lend support to this plan. It is believed rather that Long Island Hospital should be modernized and restricted to the care of the custodial type of patient who requires a minimum of medical and nursing supervision. Facilities for the care of chronic patients who are amenable to treatment and who require, therefore, some medical and nursing supervision, should be provided in connection with medical centers or general hospitals.

We believe, therefore, that a unit of approximately five hundred chronic beds should be established at the Boston City Hospital, and that "chronic" patients at Long Island Hospital whose age and physical condition indicate the need for active medical and nursing supervision be then transferred to the Boston City Hospital.

Traditionally, the care of patients with long term chronic diseases has been a responsibility of government rather than of voluntary agencies. The low occupancy of voluntary hospitals whose primary function is the care of chronic patients is noteworthy and is mainly an economic problem. We believe, however, there is need for facilities for the care of chronic patients in other than municipal hospitals. We therefore suggest that at least three units smaller than that recommended for the Boston City Hospital should be established, each in connection with a large general hospital, where proper medical and nursing supervision can be given and where clinical interest can be maintained.

In some other communities, governmental plans call for the establishment of two hundred bed units, each in connection with a medical center, built and maintained with governmental funds, but operated under contract with a voluntary general hospital. We suggest, however, that in some instances smaller units might be established in the Greater Boston Area, particularly in those hospitals which have one or more unoccupied floors. This plan presumes an interest on the part of governmental agencies in providing good facilities for chronic disease care, and presumes further that governmental agencies, in recognizing the growing importance of this problem, will also be prepared to finance the care of these patients.

The plan described briefly here should, of course, include provision for the home care of patients with chronic disease and this home care should be a projection of institutional treatment and responsibility. We urge that the Greater Boston Community Council and its component parts press actively for an improvement of facilities for such care of chronic patients in the Greater Boston Area, and that all plans should be predicated upon a partnership in responsibility between voluntary and governmental agencies.

WE RECOMMEND: (21) A unit of approximately five hundred chronic beds should be established at the Boston City Hospital and "chronic" patients at Long Island Hospital, whose age and physical condition indicate the need for active medical and nursing supervision, should then be transferred to the Boston City Hospital.

(22) Provided only that the full cost of care of public assistance chronic patients be accepted as the responsibility of the governmental agency concerned, and that government funds be provided for any new construction, at least three additional smaller units should be established, each in connection with a large general hospital.

(23) The inauguration of a home care program for the care of chronic patients should be studied by the Hospital Council in collaboration with other interested agencies.

(*Note:* Since the survey conducted by the Hospital Division was commenced, facilities for the care of chronic patients at the Private Pavilion in Jamaica Plain of Massachusetts Memorial Hospitals have been opened, using roughly one-third of capacity therefor. The recommendations in this Report, therefore, should be regarded in the light of the success or failure after trial of the new venture.)

*Nursing Education*

In the Greater Boston Area twenty-six hospitals conduct schools for student nurses. One school, in cooperation with Radcliffe College, offers "a coordinated program for the preparation of a limited number of selected young women who wish both a broad general education and a professional education in nursing." In addition, Boston College, Boston University, and Simmons College offer basic professional programs and advanced professional programs open to graduate nurses.

In June, 1948, the total enrollment in all schools was 2,523, as compared with 2,780 in June 1947. During that year, enrollment in the schools ranged from 31 to 255, with an average of 87 students per school. Approximately one-third of the schools had a student body of one hundred or more. The autumn 1948 enrollment was approximately 875, a marked improvement in comparison with the autumn enrollment of the previous two years.

Today central schools of nursing have proved their worth in many sections of the country, both in raising the quality of the educational program and in economy of operation. Progress in accepting the central school has been slow in many communities. During a period of shortage of graduate nursing personnel, there is hesitation in recommending the abandonment of smaller schools of nursing; but, under any circumstances, small schools should affiliate with larger or central schools for their preclinical or basic science instruction of the first six or nine months of the three year course. Student nurses could then return to the parent hospital for nursing arts instruction and the remainder of their course in nursing.

The three year diploma course has been attacked in some quarters. In a report of a Committee of the American Medical Association in 1948, the recommendation was made that this course be cut to one or two years, and in a recent study by Dr. Esther Brown, entitled "Nursing for the Future," the same proposal is made. The cold economics of this question, however, deserve some attention.

The student who enrolls in a three-year diploma course is working her way through a school of nursing. Three years of college would cost her approximately $4,500 in cash for maintenance and tuition. In a school of nursing, the outlay in cash by her in three years is about one-tenth of this amount. Without subsidy, the hospital expects in fairness to balance the account by work done. Good schools of nursing now give over 1,200 or 1,300 hours of instruction during the three years, and this is more than double that advocated by the National League of Nursing Education thirty years ago.

About ninety per cent of class hours are in the first and second years and almost half of the total hours of nursing service of students falls in the third year of the course. If this third year were dropped, it is clear that a subsidy system would be necessary. No one can quarrel with Dr. Esther Brown and others who recommend added financial support or subsidy; but, pending governmental or other action, hospitals should not be criticized for providing an instrument of instruction on the only available basis of finance.

> We Recommend: (24) From the community standpoint and in the development of a long range program in nursing education in the Greater Boston Area, the possibility of a central school or schools of nursing for instruction in the basic sciences should be the subject of immediate and thorough study.

*Nursing Service*

In this country and in Canada, hospitals continue to be faced with a shortage of nursing service personnel, and this shortage is mainly a quantitative one. A review of the number of students recruited and graduated each year leaves little hope that an adequate supply of graduate nurses can ever be obtained. Many leaders in the field believe that the answer lies in a change in the present pattern of nursing service. It has been demonstrated in many hospitals that a well-trained subsidiary group, under good supervision, can carry successfully the bulk of the bedside nursing care. This may well be the pattern for bedside nursing care in the future. The increasing cost of professional nurse care has also emphasized the need for a revaluation of the present thinking of what constitutes an adequate nursing service.

The adequacy of a nursing service is frequently expressed in terms of the number of bedside care nursing hours per patient day. To analyze the nursing service quantitatively, a study was made of the bedside care personnel hours during the period September 27th through October 2nd. A full description of this study, a discussion of the norms or standards used, and several tables setting forth the results in detail are contained in our full Hospital Report.

By the accepted standards it would appear that hospitals in Greater Boston have an adequate supply of persons giving nursing service in most areas. On only one service, Obstetrics (mothers and infants), is there any marked shortage. On most services, the hours of nursing service per patient day exceed the standard. The ratio of graduate hours to student hours to subsidiary hours is also generally satisfactory. The amount of nursing service rendered is higher than obtains in many sections of the country, and the complaints of shortage in the Greater Boston Area are not supported by the results of this study.

In the analyses of nursing service in the individual hospitals, there appeared to be a maldistribution of graduate nurses — some units having an excess of graduate nurses, while other units have too few.

The proportion of care furnished by subsidiary personnel in the majority of Greater Boston hospitals is under the conservative estimate given in a study by the National League of Nursing Education in 1948. That study concluded that only 30 to 35 per cent of the care needed on the medical and surgical service should be given by non-professional help. Many qualified persons feel that a much greater percentage can be given by this group under good professional supervision. One Boston hospital found, on the basis of experience, that 50 per cent of the bedside care could be given by a trained subsidiary group.

The use of subsidiary personnel to meet the needs of the nursing service appears to be low, but it may be due to conditions beyond control of the hospital. There have been and are many administrative problems which remain to be solved in the use of this group. Many directors of nursing feel that there is a place for such workers, but that the problem needs study. More than one hundred trained "licensed attendants" are employed in the thirty hospitals studied. These attendants are mainly graduates of one or other of the four schools for such attendants in the Greater Boston Area. These schools should have

a closer affiliation with general hospitals for the clinical portion of their training. Such affiliation should be effected also with some general hospitals which have schools for the training of registered nurses. We suggest further that some smaller schools of nursing be discontinued and replaced by training schools for "licensed attendants."

It is evident that the migration, on graduation, of student nurses from Massachusetts to other parts of the country is excessive. In 1946, for example, 653 nurses left the state to be licensed elsewhere, whereas only 343 out-of-state nurses were licensed that year in Massachusetts. From interviews with a number of Directors of Nursing in the Greater Boston Area, it appears that this is a real problem in Greater Boston hospitals. Matrimony cannot be the main reason for this exodus. One reason may be the immigration of many persons from outside of Greater Boston to take training at Boston's medical centers, and their return home after such training. We suggest that more attention be given to personnel policies in the Greater Boston Area hospitals. In 1948 half of the hospitals were still clinging to the 48-hour week. Only nine hospitals are on a 40-hour week.

We Recommend: (25) More encouragement should be given to the expansion of schools for "licensed attendants"; there should be a closer relationship between these schools and general hospitals; and consideration should be given to the replacement of some smaller schools of nursing by training schools for "licensed attendants."

(26) Attention should be directed by the Hospital Council to the personnel policies in member hospitals, with a view to establishing greater uniformity and an improvement in relationship between hospitals and their nursing personnel.

## *GENERAL SUBJECTS*

*Medical School and Hospital Teaching Affiliations*

The preeminence of Boston as a Medical Center is recognized largely in the achievements of its three Medical Schools and the nineteen voluntary and six governmental hospitals which are affiliated with them. Inevitably and frequently a question is raised about the financial contribution made by hospitals to medical education and by medical schools to hospital care. It is impossible to determine accurately under present systems of cost analysis the proper division of expense under the headings of Medical Education, Research and Patient Care.

Funds for medical education should not be diverted to use for the care of medically indigent patients. On the other hand, patients selected and admitted primarily for medical teaching should not be a charge only upon the hospital.

It is evident that there are varying degrees of financial assistance in each direction among the teaching hospitals and the medical schools of the Boston area. It is evident also that medical schools are not paying for patients' care. Indeed, it may be pointed out that the use of voluntary hospitals by the Boston Medical Schools relieves the Universities concerned of a financial load which in some comparable universities is a heavy one.

The obvious trend from the ward type of patient care to the semi-private classification is inevitable under the impact of a growing volume of hospital insurance. This trend will provoke the need for a study of staff organization to meet the problem. The most obvious answer is the use of semi-private and private patients for undergraduate medical instruction. Some teaching hospitals have for many years made acceptance of this principle a requirement for staff membership.

The relationship of the medical schools to the Boston City Hospital receives particular mention in that part of the report which deals with the Boston City Hospital.

*Mental Care Facilities*

The great majority (98%) of the hospital beds for the care of mental illness in Massachusetts are in hospitals administered by governmental agencies, usually state agencies. It seems inadvisable, therefore, to attempt to designate a ratio of mental beds per thousand population in the Greater Boston Community Fund area alone.

The Massachusetts State Plan for the Administration of Public Law 725 lists 21,102 existing acceptable mental beds in the state. This gives a ratio of 4.6 beds per 1,000 population, while the recommended ratio is at least 5 beds per 1,000 population. These facilities are used almost wholly for psychotic patients. A Veterans' Administration hospital of 1,000 beds has been planned for construction within the area.

In the Greater Boston Community Fund Area, except for one unit of 18 beds, there are no reported facilities for the care of psychiatric but non-psychotic in-patients in general hospitals, and there are only about six general hospitals in the area having psychiatric out-patient facilities. There is a growing need for the provision of hospital in-patient accommodation for emotionally disturbed patients who are amenable to modern psychiatric treatment, and it is important that these patients be regarded in the same light as those suffering from other medical disabilities. Indeed, the importance of intimate association between the Departments of Medicine and Psychiatry cannot be overemphasized. For this reason it is urged that the short term treatment of the milder mental disorders of the non-psychotic patient be carried out in a general hospital with all the facilities for clinical consultation and diagnostic service.

We Recommend: (27) That consideration should be given to the need for facilities for the diagnosis and short-term in-patient care of emotionally disturbed patients as integral parts of some of the larger voluntary general hospitals in the Boston area.

*Obstetrical Facilities in Hospitals*

In reviewing maternity care in hospitals, an analysis of facilities was made according to type and size of hospitals and number of births. It was impossible to obtain the total number of maternity beds in the Greater Boston Area as questionnaires were not returned from all hospitals.

In 1947, 81% of the hospital births in this Area were in voluntary hospitals, 16% in governmental hospitals, and 3% in proprietary hospitals.

It is noteworthy that in the medical center area of Boston, only 15% of the hospital births were in institutions having an approved pediatric residency, and only 36% were in institutions having an approved obstetrical residency.

We Recommend: (28) That a resident staff rotation system should be developed further to provide greater training opportunities and to afford better specialized service in those hospitals which are not now approved for residency training in obstetrics.

*Regionalization of Hospitals*

It is believed that the Greater Boston Area does not lend itself easily now to a regional pattern as envisaged, for example, by the United States Public Health Service. There are hospitals of all three principal classifications within the area, but the complexity of existing relationships with medical schools makes difficult any blue print of affiliation on a geographical basis. It is evident, however, that there is a duplication and waste in the operation of small units which are in proximity to each other and that some consolidations or mergers are possible.

The advantages of developing further the medical staff affiliations between the primary and secondary teaching hospitals and the other hospitals are worthy of study. We think the greatest immediate advantage would be an extension of the system of rotation of resident staff from the larger to the smaller hospitals. A pattern already exists for this in some hospitals of Boston and in such other centers as Richmond, Va., Detroit, Mich., and Rochester, N. Y., and experience has shown it to be of value to both hospital partners in the enterprise.

We Recommend: (29) That the system of rotation of members of resident staffs of larger hospitals to smaller hospitals in the Greater Boston Area should be extended within the limits of good medical supervision by the larger hospitals, and of teaching interest of the smaller ones.

*Tuberculosis Hospitals*

There are no segregated facilities for the care of patients with tuberculosis in any general hospital in the Greater Boston Area.

Ninety-two per cent of tuberculosis hospital bed facilities in the State of Massachusetts are in governmental hospitals, most of which are state-owned. It is difficult to say exactly how many beds are available only for residents of the Greater Boston Area. It seems advisable, therefore, to list needs and facilities for tuberculosis care on a State rather than on an Area basis. Since no attempt was made to survey these facilities throughout Massachusetts, the figures for existing acceptable beds given in the "Massachusetts State Plan for the Administration of Public Law 725" are used. There are 3,604 beds in existing hospitals for tuberculosis. It is generally accepted that such facilities are necessary in the ratio of two beds for each T.B. death. There is a need, therefore, for 4,400 T.B. beds; on which basis Massachusetts needs 800 more beds for the care of tuberculosis patients.

We think the treatment of tuberculosis patients should be integrated more with that of patients in a general hospital, and that additional specialized facilities should not be built at a distance from those for general medical and surgical care.

We Recommend: (30) That new construction of tuberculosis facilities should be in conjunction with general hospitals in the urban areas rather than as additions to or replacements of existing sanitoria.

*Medical Social Service*

This important activity of hospitals is dealt with in the report of the Voluntary Casework Division of the Survey.

## *SPECIAL SUBJECTS*

*Boston City Hospital*

This institution is being extensively studied under the direction of the Finance Commission of the City of Boston. It should be emphasized, however, that the Boston City Hospital is important not only in the provision of hospital care in Boston, but also in the medical and nursing programs of education and training of the entire Area. It should continue, therefore, to participate actively in the Hospital Council.

The City of Boston is fortunate to have three outstanding medical schools located in the City and to have faculty members from these schools available for the clinical care of the patients in the City Hospital. But difficulties in the defining of responsibility and in the system of staff appointment have created friction to the point of withdrawal by some medical school departments from the use of Boston City Hospital for under-graduate instruction. It is trite to mention that appointment to the medical staff of the Hospital should be based on merit alone; but merit appointments are more likely to be achieved if appointment is made by the Board of Trustees of the Hospital on the recommendation of a Joint Educational Committee of the three medical schools. The Medical Director of the Hospital should be a member of this Committee. If such a plan is followed, there should be a clear understanding of the relationship between the Medical Director and Board of Trustees who are responsible for the administration of the Hospital, and the professional staff who are responsible for the clinical care of the patients. No physician in active practice, of course, should be a member of the Board of Trustees of the Hospital.

We think the three hospitals which are operated by the City of Boston, i.e., Boston City Hospital, Long Island Hospital and Sanatorium Division, should be placed under unified control and administration.

The South Department of the Boston City Hospital (the "pest house" division for contagious disease) is obsolete. It should be replaced by a unit of approximately 500 beds for chronic patients and by a modern unit for the care of patients with communicable disease other than tuberculosis. Both of these units should be closely integrated with the main Hospital to insure active and continued interest of the professional staff.

We Recommend: (31) That the professional staff of the Boston City Hospital should be appointed annually by the Board of Trustees of the Hospital on the recommendation of a Joint Educational Committee which includes in its membership the Dean of each of the three medical schools and the Medical Director of the Hospital; and responsibility for clinical care and for resident staff training should be divided by agreement among the three medical school faculties.

(32) No physician in active medical practice should be a member of the Board of Trustees of the Boston City Hospital.

(33) The South Department for contagious disease of Boston City Hospital should be demolished and replaced by integrated facilities for the care of approximately five hundred chronic patients who require medical and nursing supervision and also by a modern unit for the treatment of contagious disease other than tuberculosis.

(34) The Boston City Hospital, the Long Island Hospital and the Sanatorium Division should be placed under unified control and administration.

*Boston Evening Clinic*

This agency offers diagnostic and treatment facilities to patients of moderate income. Its policy is to accept patients who are unable conveniently to consult private physicians. Its location is good and

it might well be developed to an efficient instrument of group practice for patients of moderate means. A school for physio-therapy technicians and one for laboratory technicians is conducted, but neither is approved by certifying agencies. It is suggested that a revision of admitting policy and procedure in this clinic would make unnecessary any outside financial subsidy.

We Recommend: (35) That the present organization and administration of the Boston Evening Clinic should be modified; and that it should be considered not eligible to receive Community Fund monies.

*Free Hospital for Women*

One of the many small hospitals in the Boston area which is unique in its method of collection is the Free Hospital for Women. Because of its charter, patients are not requested to pay the bill, but instead to give a donation. Business-like policies and procedures are hindered by such a restriction. It is observed that a modern and attractive office building is provided on the grounds of this hospital, without rental charge to physicians for their offices.

We Recommend: (36) That legal assistance should be sought with a view to revision of the corporate name of Free Hospital for Women, and of the charter restrictions in respect to the charging of patients, in order that the hospital may assume the same character as other modern voluntary hospitals.

*Massachusetts Women's Hospital*

This is one of the smaller Boston hospitals which attempts to give all types of medical care. It has 66 beds in two buildings connected by a ramp. The main building is of frame construction and was purchased in 1891. It has been remodelled to provide office space, some service facilities, and 32 patient beds. Maintenance of this building has always been extensive and expensive. A new brick wing, containing 34 beds and some service facilities, was constructed in 1927. These facilities are modern and attractive but poorly arranged.

We Recommend: (37) That, in view of the size of the Massachusetts Women's Hospital, the inadequate physical plant, and its proximity to the New England Baptist Hospital, the Massachusetts Women's Hospital and the New England Baptist Hospital should be merged into one institution.

*Maverick Dispensary*

In a crowded tenement type of house, this agency attempts to give dispensary service mainly to people in East Boston (approximately 50 per cent of whom are foreign born). There are no diagnostic facilities on the premises for other than routine matters. A nearby City Health Center does not offer hospital out-patient care, but patients from this section may go by rapid transit to well-equipped and staffed hospital out-patient services in Boston. In view of the foregoing, the continuance of this agency is no longer supported by the valid reason which caused its original establishment.

We Recommend: (38) That the Maverick Dispensary be discontinued.

*Maternity Homes for Unmarried Mothers*

We discuss here only the hospital care facilities in maternity homes for unmarried mothers, and comments are made only on Hastings House and the Florence Crittenton Maternity Home and Hospital. Each of these institutions has a complete hospital unit within a home developed primarily for the segregation of unmarried mothers during their pregnancy and post partum period. These homes place great emphasis on the need for secrecy and therefore have made available within the institutions all necessary facilities for complete care of the mother.

Information on the cost of rendering these hospital services to a segregated group of patients was not available. Since the total number of deliveries in both homes in 1947 was only 137, it is apparently an expensive program of obstetrical and pediatric care. Hastings House purchases medical service for very small fees from private physicians. Florence Crittenton Maternity Home and Hospital receives professional help as an extension of resident service of the Boston Lying-In Hospital and the Massachusetts General Hospital.

We Recommend: (39) That the various agencies providing maternity care for the unmarried mother should consolidate efforts and facilities in order that the volume of work may be sufficient to justify the full operation of a hospital obstetrical unit; or, failing this, that the

actual hospital care be rendered in general hospitals, preferably teaching institutions. (See Report on Voluntary Child Care Services — Voluntary Casework Division.)

*New England Hospital for Women and Children*

This hospital was organized in 1863 to provide hospital and training facilities for women physicians who were not then eligible for staff interneships in other hospitals. The changed attitude of 1948 on the subject of women in medicine raises a serious question of the wisdom of continuing separate and designated hospitals for women in training and in medical practice.

The governing board of the hospital is concerned about the mounting deficit, the lowered census, and the problems of maintenance and administration which result from a mixture of old and other buildings containing small and uneconomical nursing units. Efforts should be made to increase the number of private and semi-private patients in the hospital by conversion to this type of accommodation in the medical, surgical, and obstetrical wards and in part of the unused pediatric floor. The admitting policy of the hospital should be that of caring for ward patients up to the financial ability of the hospital to provide such care.

Because the New England Hospital for Women and Children fits a need in the area in which it is located, we suggest that consideration be given to enlarging the staff with the emphasis upon clinical competence rather than upon sex. The addition of competent men physicians to the staff would increase the demand for the facilities of the hospital. The present teaching association with Tufts Medical School should be encouraged and expanded.

We Recommend: (40) That the New England Hospital for Women and Children should abandon its policy of restricting medical staff appointments to women; an increased number of beds should be made available for private and semi-private patients by conversion of ward beds; and ward patient care should be limited to the available resources of the hospital.

*New England Medical Center*

Progress is being made in the consolidation of the corporate structure, the medical staffs, and the administration of the several components of the New England Medical Center — (Pratt Diagnostic Clinic, Boston Dispensary, Boston Floating Hospital, and the Service Unit of the Center). It is important that this be done to overcome the existing confusion of administrative and staff relationships.

Construction in progress will add approximately 170 beds to the 80 now available to provide a total accommodation of 250 beds. The Ziskind Laboratories are also being remodeled. A suggestion has been made that about fifty beds be added at the Boston Dispensary. This appears to be unwise, if there is to be a closer relationship between the medical staffs of the units of the Center.

For many years the Boston Dispensary has provided a unique and valuable service to the citizens of Boston, which continues even though considerable sums of charitable monies are required. This Home Care program of the Boston Dispensary provides care for the "medically indigent" of Boston, without reimbursement from the City.

Many of the patients coming to the Boston Dispensary are unable to pay the full cost of the service obtained. They should, however, be given the opportunity of paying full costs when this is possible. Reduced fees should be accepted, of course, according to the circumstances of the patient. But the rate structure should be based upon cost and there should be a consistent admitting policy. The determination of financial eligibility and the setting of fees is not a proper function of workers in a social service department.

We Recommend: (41) That a consolidation of the corporate structure of the medical staffs and of the administration of the various units of the New England Medical Center should be effected as soon as possible and a close relationship should be maintained with the faculty of the Tufts Medical School.

(42) In view of the possible consolidation of units of the New England Medical Center, the Boston Dispensary should not add hospital in-patient facilities.

(43) The City of Boston should pay the full cost of the services rendered by the Boston Dispensary, under its Home Care Program, to clients in all categories of public assistance.

(44) A review of the charge schedules and admitting policies of the Boston Dispensary should be made; the rates should be based on approximate cost, with allowances made to patients unable to pay the full rate; and all admitting appraisals and procedures should be a responsibility of the admitting officer.

*Norwood Hospital*

Norwood Hospital has recently purchased the former Sharon Sanitarium in order to increase the beds necessary for the requirements of that area. It is planned to convert the Sanitarium plant, at a cost of approximately $400,000, to provide 50 adult medical beds and 24 pediatric beds.

The Sharon Sanitarium is five miles from the Norwood Hospital, does not have a particularly satisfactory physical plant, and will undoubtedly be expensive to administer. Two units, one of 132 beds and one of 74, cannot be run as economically as one unit of 200 beds.

We Recommend: (45) That reconsideration should be given to the expansion of the Norwood Hospital with a view to the consolidation of its facilities.

*Robert Breck Brigham Hospital*

Operating for the most part as a hospital for the treatment of chronic diseases, but caring also for other medical and surgical patients, this institution of 103 beds has had, during the past ten years, an average occupancy rate ranging from a high of 84 per cent in 1941, to a low of 67 per cent in 1947. The percentage of ward days to total days has dropped from 65 per cent in 1938 to 53 per cent in 1947. At the present time there are unoccupied ward or "public" beds, because admission is restricted mainly to patients who are "settled" in Boston and because so many patients cannot pay the charges for ward care. At the same time, there is a waiting list for private and semi-private accommodations.

We Recommend: (46) That facilities which are now set aside for ward public patients should be made available or converted for the use of private or semi-private patients at Robert Breck Brigham Hospital.

(47) The assistance of the Greater Boston Community Council should be offered to the Board of the Robert Breck Brigham Hospital for study of the probable future adaptability of the hospital to chronic or acute care, in the light of governmental payment for the care of patients in these two categories.

*The Washingtonian Hospital*

An effort is being made in many communities to provide better facilities for the care of alcoholics. In the Greater Boston Area these patients are admitted to the Boston City Hospital and to the Washingtonian Hospital. At the Boston City Hospital, the treatment consists mainly of a "defrosting" during the acute stage. At the Washingtonian Hospital, rehabilitation is attempted; an unusually high percentage of those who undergo the "conditioned reflex treatment" do not relapse. At this hospital also, of course, many patients do not remain beyond the acute or sobering-up stage, but a sincere attempt is always made to provide follow-up treatment.

The physical facilities of the Washingtonian Hospital are poor and it is to be hoped that the property may be sold for commercial use and a more attractive one obtained on the outskirts of the city. More emphasis should be placed on psychotherapy and social therapy and, if funds were available, some investigative work should be done in personality studies and in biochemical and physiological problems in this field. Steps to strengthen the Board of Trustees have recently been taken and further additions should be made from persons active in the business community.

We Recommend: (48) That the Washingtonian Hospital should receive an increased appropriation from the Community Fund for the next two years; the Board of Trustees should be strengthened by the addition of persons active in the business community; greater efforts should be made to enlist the active interest of psychiatrists and other physicians and of other citizens of prominence in the work of the hospital; and the status of the institution should be reviewed by the Hospital Council at the end of the two-year period.

*Children's Medical Center*

The development of a sound plan for a medical center to furnish all types of medical and hospital care to children of any age or economic status makes necessary a close coordination of facilities and activities. This can be done much more effectively under a single administrative board. The present plans for the reconstruction of Children's Hospital appear to be good, but it is important that consideration be given to the need for consolidating all activities at the Center itself.

The occupancy rate at the Convalescent Home for Children in Wellesley has been low, something over 60 per cent, due apparently to a lessened need for such facilities rather than to an inability of patients to afford this care. We suggest that this institution be closed and that these patients be admitted

to the House of the Good Samaritan. The proximity of the latter to the Children's Hospital obviates the transportation difficulties which are presented by the Convalescent Home. This would necessitate a change in the admitting policies for the House of the Good Samaritan to include patients other than those with rheumatic fever. It should not interfere with the present high type of specialized care being rendered in this institution, however, for segregation of patients on different floors by type of illness may readily be effected.

If the need for beds for chronic and convalescent care increases, additional construction would be indicated immediately adjacent to either the House of the Good Samaritan or to the Children's Hospital. Consideration should be given also to the development of a home care plan, extending medical care into homes and foster homes.

> We Recommend: (49) That the units of the Children's Medical Center should operate under one administration with consolidated medical staffs; and wherever possible merge and consolidate into one corporate structure.
>
> (50) The Convalescent Home for Children should be closed; and, until new construction is available at the Children's Medical Center, patients now at the Convalescent Home for Children should be cared for in the part of the Center now designated as the House of the Good Samaritan.
>
> (51) The feasibility of extending medical care from the Center to the homes and foster homes by the development of a home care plan be studied by the Children's Medical Center.

*Children's Mission to Children*

It appears that the "medical homes" part of the Children's Mission to Children is essentially a "home service" medical plan for various Boston hospitals and dispensaries (Boston Dispensary, Massachusetts General Hospital, Boston City, and Children's Hospital), with the additional feature of the actual provision of a home for the child. In this way it combines child placement with provision and supervision of medical care.

It would seem a better administrative procedure to have the provision of medical care a responsibility of a hospital (i.e., any of the above institutions). In this way the "medical homes" could be operated by the Children's Medical Center or the Massachusetts General Hospital on the principle of cottage type convalescent homes. The medical supervision should be a responsibility of the medical staff of the hospital and should provide a good additional experience for the pediatric resident.

Child placement is not accepted as an ordinary responsibility of hospitals and therefore the placement of children in "non-medical homes" should be transferred to a regular child placement agency. (Such placement in 1946 comprised about 60% of all placements made by the Children's Mission to Children.)

> We Recommend: (52) That the Children's Mission to Children should merge or affiliate with a hospital having a children's service. (See Report on Voluntary Child Care Services, Voluntary Casework Division.)

*Massachusetts Memorial Hospitals*

In addition to the main unit, there is a Contagious Disease Unit and a Private Pavilion (in Jamaica Plain) for semi-private and private patients. These ancillary facilities are distant from each other and from the central hospital; and the low occupancy and high cost of a decentralized system have caused concern.

The Contagious Disease Unit serves mainly the communities outside of Municipal Boston. Its average occupany is about 41%. Unquestionably this unit serves a useful purpose and it is stated that its income equals its expense. We suggest, however, that a careful cost accounting be made to determine as accurately as possible its income and expense status. The need for such a facility for the care of patients with contagious diseases should also be reviewed. If continued, plans should be made to incorporate it with the Central Division of Massachusetts Memorial as soon as possible. Specialized units of this kind function better when integrated closely with a general hospital.

The Private Pavilion is currently operating at about fifty per cent of its capacity and this decentralization of care is costly and inefficient. The financial problems of Massachusetts Memorial Hospitals are such that immediate consideration should be given to consolidation of all its units at the Central Division. At the main unit an unoccupied floor of 20 beds could be utilized. Another floor of 36 beds is devoted to the fluctuating demands of maternity care. So important is the need for pulling together

the separate units, that the Massachusetts Memorial might well abandon entirely its obstetrical service. At least 56 additional beds could thus be used for semi-private and private patients and the present Private Pavilion could be closed.

No plans have been made for reconstruction of the Massachusetts Memorial beyond minor projects of refurbishment. A master plan should be drawn to provide rebuilding in stages or units and looking toward the eventual goal of a modern centralized hospital. The most obsolete sections should, of course, receive first attention, e.g. the Out-Patient Department. The laundry building and equipment should be scrapped. A new laundry is needed; or, as mentioned elsewhere in this report, the laundry facilities should be merged with those of the Massachusetts General or of some other hospital.

In view of the increasing demand for semi-private accommodation, thought should be given to the possibility of conversion of ward beds for this class of patients.

We Recommend: (53) The Massachusetts Memorial Hospitals should consider the discontinuance of its obstetrical service.

(54) Attention should be given at once to the desirability of consolidating all activities of the Massachusetts Memorial Hospitals at the Central Division.

(55) A master plan should be drawn for the reconstruction of the Massachusetts Memorial Hospitals; capital funds should be sought; and a program of building in stages or units should be undertaken as soon as possible.

(56) A study should be made of the possibility of converting ward beds at the Massachusetts Memorial Hospitals to a flexible type of semi-private and private accommodation to meet the increased demand for this type of hospital care.

# V. Individual Services to Families, Children, and Adults

*Introduction*

Social welfare policies and practices have changed with time toward a more discernible differentiation of the respective responsibilities of voluntary and tax-supported agencies. Today, public welfare, both by law and in practice, has, or should have, facilities in funds and personnel to provide the minimum essentials of basic maintenance for those who are in need. Public welfare is also moving more and more into preventive methods, thus sharpening the need for distinction and working definitions between its responsibility and that of voluntary effort.

Voluntary social service has continued to develop skills, personnel and resources in its primary aim to cure and prevent family and individual maladjustment. Financial assistance has a legitimate and important place in voluntary social service as an adjunct to this primary aim. Today, however, voluntary agencies recognize that they cannot provide basic maintenance. The limited financial assistance they give has validity only if used constructively toward more healthful personal adjustment and achievement. In time, and as additional uses of specialized financial assistance have established real preventive and rehabilitative values, public welfare will assume still more of this area of financial relief as a proper public responsibility.

The citizens of Greater Boston must assume an equal concern and responsibility for tax-supported and voluntary effort in social welfare. As contributors and directors of voluntary activities, they can more promptly and wisely effect adjustments in policy and practice in the voluntary field, as against bringing about, as taxpayers, similar rearrangements in the public field. Yet part of the solution of Greater Boston's welfare dilemma depends on a clarification of the respective roles which tax-supported and voluntary programs should play in the total scheme of helping people.

In establishing an over-all plan and guiding policy for the voluntary field of social service, these generalized definitions of respective areas of basic responsibility must be the starting point. Thereafter, the variations, flexibilities and more specific definitions can be worked out, and further adaptations and refinements in practice or policy made.

Tax-supported agencies spend much more money than voluntary agencies and provide the basic services to families, children and adults on which the services of voluntary agencies rest. Therefore, our report first presents our findings on tax-supported agencies (Section A). These findings are based on a study of tax-supported public welfare in 18 cities and towns in the Metropolitan Area (not including the City of Boston).

Section A is followed by summaries of 14 of our full reports on voluntary agency work in the field of individual services to families, children, and adults (Section B). Two of these summaries, it should be noted, deal more with public agencies than with voluntary agencies — in Child Care: the report on the Division of Child Guardianship in the State Department of Public Welfare, and the report on the Juvenile Offenders. At the risk of offending our own logic, these reports are included in Section B because they deal with subjects so closely related to other subjects there treated.

## A. Public Welfare in the Metropolitan Area[1]

The Report of our Division of Public Welfare includes the study of general relief, aid to dependent children, and old age assistance as it is administered by the following cities and towns:

| | | | |
|---|---|---|---|
| Braintree | Hull | Quincy | Walpole |
| Concord | Malden | Reading | Watertown |
| Everett | Melrose | Scituate | Winchester |
| Hingham | Milton | Somerville | |
| Holliston | Natick | Wakefield | |

[1]Our study of public assistance (general relief; aid to dependent children; old age assistance) was limited to 18 cities and towns in the Metropolitan Area, selected to provide a cross-section of the entire Area. Public assistance in Municipal Boston was not included, because late in the spring of 1948 the General Court of Massachusetts passed an Act directing the Boston Finance Commission "forthwith to make an administrative survey, analysis and appraisal" of every department or other unit of the government of City of Boston. The Board of Overseers of the Public Welfare in the City of Boston decided not to take part in our Survey.. The Finance Commission's study of public welfare in the City of Boston was made by Dr. White, who directed our study of public welfare and wrote our full report. Dr. White's study for the Finance Commission, when published and available, will be filed with the reports of this Survey and can be consulted there.

Cities and towns in the Metropolitan Area with very small public assistance caseloads were excluded as a matter of expediency; to have studied them would have required more effort than the probable results would make worth-while. The Boards of Public Welfare in a few of the larger Metropolitan Cities and Towns decided not to take part in our Survey. The 18 communities studied give us a fair perspective of the whole Metropolitan Area.

The following principles formed the basis for our judgment of public welfare programs:

(1) There is a common recognition that every individual and family has a right to a standard of living which affords basic essentials for health and social usefulness. Evidence indicates that society has the clear intent to provide those basic essentials to persons unable to maintain that standard for themselves.

(2) Public welfare law and court decision define and implement this intent of society by establishing the basic economic, medical and protective services for those in need. (Protective services, as the term is here used, are those services given by a public welfare agency after court action with respect to a child or adult.)

(3) The effectiveness of a public welfare agency is measured by the degree to which, acting within its legal powers, it promotes the well being and social usefulness of the individual whom it serves, and protects both the individual and society where such protection is required.

(4) Tax-supported and voluntary agencies are engaged in a common enterprise, but for practical reasons there must be a division of activities. In general, it is the duty of the tax-supported agency to provide the basic essentials for health and social usefulness. Likewise, in general, it is the province of the voluntary agency to meet special needs not served by the public welfare agencies at the time and to experiment with new ways of meeting human need. This division of the field is not absolute but expedient, and continuous cooperative planning and redefinition of duties are necessary.

(5) Maximum value from the expenditure of the tax dollar for the basic economic, medical and protective services can best be obtained by careful coordination with services provided by voluntary contributions.

*The Public Assistance Law*

In the public assistance field there are three categories of relief: (1) old age assistance; (2) aid to dependent children; (3) general relief. (1) The law provides that persons 65 years of age or older who meet certain specified conditions may receive *old age assistance.* Barring the question of American citizenship, the rights of the aged have been defined so generously and so clearly that it is difficult for a public welfare board or employee to make mistakes in the mechanical administration of this law. (2) The law creating and requiring *aid to dependent children* is more complex and necessarily requires more discretion on the part of public welfare social workers and boards. The federal and state governments reimburse the local communities for more than four-fifths of the cost of old age assistance and for considerably more than half of the cost of aid to dependent children. General relief is another matter. (3) The State pays the entire cost of *general relief* cases which are without "settlement" in a specific community, but about three-fourths of all general relief cases have "settlement" and are the complete responsibility of the local community, the local agency determining both eligibility for assistance and the amount needed. Most communities define this amount in more parsimonious terms than is done in the case of old age assistance and aid to dependent children, in which two latter categories the State Department of Public Welfare determines a standard of assistance that is mandatory in local communities. This is unfortunate, because general relief is the most flexible of all forms of assistance: the only condition of eligibility is economic need, and the amount should be based upon a rational budget comparable to that used in the special categories of assistance.

*The Board of Public Welfare*

In 16 of the 18 communities studied, administration of public assistance is the responsibility of a Board of Public Welfare. It is the statutory duty of the board to give aid to any person in need who resides or is found within its jurisdiction. To carry out this duty, the board "may appoint an agent" but is not required to do so. Except in the smallest towns, the board must have "an agent"; and having an agent in any but rather small towns means having an agent with other employees, who are known as social workers and clerks. Of the 16 boards whose departments were studied, some had three members, some five; some had women members, some had only men; some were salaried, some were not.

*How the Board Acts.* In the case of a considerable number of the boards the members — perhaps because of their membership in an "administrative board" — did not delegate sufficient responsibility and authority to the agent and staff to assure smooth operation of the agency. Board interference with staff members in the performance of duties which the staff is employed to perform, or assumption of

such duties by public welfare boards, are among the reasons for inadequate public welfare service in towns and cities.

Our study of the 18 communities mentioned seemed to warrant a classification of their boards of public welfare as follows:

| | Classification and Rank | Number of Towns and Cities |
|---|---|---|
| I | Boards giving leadership and concerned mainly with policy-making | 6 |
| II | Boards where staff makes decisions on cases but Board reviews them routinely | 4 |
| III | Boards which make all decisions on eligibility | 3 |
| IV | Boards which act as "rubber stamps" and give no leadership or towns without boards | 5 |

In general, the best agencies had boards which could be given Rank I — that is, they acted *as if* they were policy-making boards and they gave constructive leadership to the staff. Neither the board that interfered in the details of administration, nor the board that performed its job in a perfunctory manner, showed as good results in any community as was found in communities where the board operated as a policy-making board.

*Changes Needed*

Because there is such confusion among board members and boards as to how they should conduct themselves and the business of their departments, the law needs several amendments. We believe that Chapter 41 of the General Laws should be amended by repealing all references to boards of public welfare, and that Chapter 117 should be amended, especially Section 2 and other sections referring to "powers and duties of boards," by repealing the provisions dealing with general administrative powers and duties of boards and by providing for a department with specific powers and duties. This department should be headed by a board whose powers and duties consist of appointing a "director" — the term "agent" should be removed from the law by amendments wherever it appears — and adopting rules and regulations. Such a board should, in addition, develop with the "director" means of informing itself on the work of the department without interfering in the details of administration or becoming a domineering body; it should play an important part in public relations; and it should act as an appeal body for grievances of both members of the staff and of applicants and clients.

In recognition of the need for legislative change, the State Department of Public Welfare requested and the Commonwealth created a Recess Commission in the spring of 1947 to recodify the public welfare structure.

Many communities in the Greater Boston Area have too small a population to make possible efficient operation in a local public welfare agency. A large public welfare department does not guarantee efficiency and economy of services, as can be seen from our Report, but it makes easier the utilitization of trained personnel to a degree which is impossible in a small department. Small contiguous towns and/or cities ought in their own self-interest to establish joint departments of welfare and employ a single staff. The General Laws should be appropriately amended to specify the procedure under which this principle could be carried into effect.

*Personnel*

The job of the staff is to bring the basic economic, medical and protective services to those in need in such a way that it achieves the goal of promoting the independence and social usefulness of each person served. To do this the agency staff should have a good understanding of human motivation and full knowledge of all the services the agency can offer and all the resources which the community offers that might be used by the agency staff to serve their clients more effectively.

*Education.* In the 18 departments of public welfare the survey found three agents with considerable professional social work education; whereas, out of 72 persons classified as social workers or social work supervisors, four had had from very little professional social work education to graduation from an accredited school of social work in one instance. In eleven of the communities studied, 58 social workers were found to have had the following general education: four held Master's degrees (only one from a school of social work); four held Bachelor's degrees, plus some graduate study; 17 held Bachelor's degrees only; and two had had less than high school graduation. More than one-third, in other words, had had only high school education or less.

While this can hardly be regarded as a satisfactory situation, it is believed that standards for recruitment of public personnel have been improving in the Commonwealth. That improvement should continue.

*Selection of Public Welfare Personnel.* Except in small towns where the members of the boards of public welfare do all the work themselves, employees of the boards of public welfare are selected through the Massachusetts civil service system. Under Massachusetts law the Civil Service Commission is prevented from prescribing educational qualifications for admission to examinations for public welfare personnel (Acts of 1935, c. 228). In the towns and cities studied, employment as a clerk for a stated number of years is regarded as a qualification for admission to examination for the position of social worker. Such a Civil Service attitude towards the qualifications required to deal with the most serious problems that human beings have is startling in the old and civilized Commonwealth of Massachusetts.

In January, 1948, the Commission on Public Expenditures and the Joint Committee on Ways and Means of the General Court of Massachusetts, made a report entitled, *A Review of Personnel Administration in the Commonwealth of Massachusetts* (prepared by the Public Administration Service of Chicago). This Review points out that responsibility for personnel administration in the Commonwealth is "so diffused that only ineffectual and excessively expensive administration can be expected to result." Veterans' preference "operates in a manner which virtually excludes other competition and which is detrimental to the general public interest." "Present exclusive reliance on seniority . . . generally discourages recruitment and retention of many able persons and lowers the standards of performance in the promotional classes." "Chief among the striking omissions in present personnel legislation is provision for in-service training and service rating activities." The Civil Service Commission, "rather than concerning itself with the broader aspects of the personnel program (as was generally intended in Chapter 13 of the General Laws), has regularly considered and decided upon many detailed administrative and technical matters." That the Commission is slow and not effective in serving cities and towns is amply supported by testimony of boards of public welfare.

In view of this picture, unless something is done promptly to remedy the situation and place a premium on youth and ability, as well as experience and ability, there can be expected a steady deterioration in the quality of public welfare service in Massachusetts and a rising cost per unit of service.

*Amount of Work Done by Social Workers.* The client and the taxpayer are interested in the quantity, as well as in the quality, of work done by the public welfare boards and staffs. We analyzed both the average caseloads per worker and number of professional workers per clerical worker. If a social worker has to carry too heavy a load, he cannot do a good job on all his cases, and such a situation is likely to result in unnecessary expenditures. Unless there is a proper balance between the social work staff and the clerical staff, the office will operate at lowered efficiency.

We found that the ratio of social work staff to clerical staff ranged from a low of 0.7 to a high of 2.2. A rigid ratio cannot be fixed and would be undesirable. It is reasonable to have a ratio of about 1.5 social work staff to one clerical staff. We conclude, therefore, that a few of the communities studied do not have enough clerical help for efficiency and that some of them have more than they need. A community that finds itself in either of these groups should examine its office organization to determine what adjustments need to be made to improve efficiency. Our full report contains a table showing the ratio for each of the 18 communities.

The matter of caseloads per worker is more complex. There are one-person cases, such as old age assistance, and there are multi-person cases, such as aid to dependent children, and both kinds appear in general relief. It is well known that a social worker can handle efficiently more one-person cases than multi-person cases. There is considerable competent opinion to the effect that a social worker can carry twice as many one-person cases as multi-person cases in the same number of hours per month.

The length of the work-week varied considerably in Greater Boston communities, but the following computation indicates the number of hours per month (4.3 work-weeks) for different length weeks:

| Hours per Week | Hours per Month |
|---|---|
| 35.0 | 151 |
| 37.5 | 161 |
| 38.0 | 163 |
| 40.0 | 172 |
| 43.0 | 185 |

All of these five different work-weeks are represented among the 18 cities and towns, but the most frequently found is the 35-hour week. Our full report gives in some detail our reasons, based on a careful

analysis of average caseloads and working hours per month for each community, and a knowledge of experiments in other communities, for believing that the workers in all but about three of the communities studied show caseloads too high for efficiency.

Proper adjustment of load to staff time can be secured either by increasing the length of the work week, and salaries by a corresponding amount, or by increasing the staff. The analysis of case records in these 18 towns and cities leads the survey staff to believe that tax money would be saved in the long run by assuring to every case of whatever kind the amount of attention which it needs, and, furthermore, since these towns and cities are fairly typical of Greater Boston, it is estimated that a corresponding proportion of other towns and cities in the area would profit by additional work on their public welfare cases.

*The Volume of Services*

*Ratio of Administrative Costs to Costs of Assistance.* Seventeen of the communities (Everett is omitted because its data were not in comparable form) in 1947 spent $5,908,864 for public assistance and $391,399 more to administer this sum. The percent of total expenditures required for administrative costs came to 6.21, varying from 3.24% in Holliston to 10.61% in Winchester. There is no way of arriving at an ideal ratio of administrative costs to total costs; but the Holliston Board of Public Welfare should inquire whether it is spending enough for administration to use public assistance funds wisely and the Winchester Board should inquire if administration costs too much for the services rendered, and if so, why.

*Determining the Amount Needed for Administration.* As said in the preceding paragraph, there is no way of arriving at an ideal ratio of administrative costs to total costs, but it is possible to make suggestions that will help.

Experiments conducted in the Department of Public Welfare in the District of Columbia revealed that a social worker, to achieve satisfactory results in that community, should spend about 1.23 hours per month on a one-person case, and about 2.45 hours per month on a multi-person case. Some study of caseloads in Greater Boston over the short period of the Survey, but independently of the District of Columbia study, revealed about the same conclusions. Recognizing the differences between Greater Boston and Washington, especially as to population and climate, we feel reasonably safe in using those figures for the following calculation.

The most common work-week in Greater Boston for departments of public welfare is 35 hours, or about 151 hours per month. In that working time, a social worker should be able to carry about 120 one-person cases, or about 60 multi-person cases, or with an undifferentiated caseload some combination of these two figures. If a worker is carrying a larger caseload, money is probably being wasted because constructive results are probably not being achieved; if a smaller caseload, money is probably being wasted because too many workers are employed.

Other considerations enter into the determination of the proportion of total expenditures which go or should go into administration. The most important of these are: (1) The ratio of social work staff to clerical staff; (2) the number of social workers per supervisor; (3) the average amount of assistance per case; and (4) salary scales. The number of clerical workers can be determined by the formula suggested above — that the ratio of social work staff to clerical staff should be about 1.5. The number of supervisors required can be held to a minimum by having the workers carry undifferentiated caseloads; for a competent supervisor can direct the work of 6 to 8 social workers quite satisfactorily, but, when the caseloads are differentiated, each type of assistance is likely to have a supervisor who is responsible for a smaller number of caseworkers. The average amount of assistance per case is important, because it probably takes no more of a social worker's time to handle cases with high average amounts than it does cases with low average amounts. If the average amount is high, the percent spent for administration will be lower for the same grade of performance. Hence the percent spent for administration may well differ among communities, because the range of mean grants per month per case in the 18 communities included in this Survey was from $52.53 to $72.81.

While the foregoing considerations may not furnish a final answer to the problem of how much should be spent for administration in a given community, they provide the basis for an effort to approach the problem in a logical manner.

*The Quality of Work*

The quality of the work which an agency does is indicated by the adequacy with which it meets the needs of the client. These needs are primarily economic, but they are also medical, familial,

vocational and recreational. Occasionally the applicant or client needs guidance to the appropriate place to obtain religious help. The towns in the survey sample which clearly are doing the best public welfare job are attempting directly or indirectly to assure the client access to whatever service his situation requires.

*Characteristics of Clients.* From a careful analysis of the caseload in each of the three kinds of public assistance under review, we can make the following statements:

(1) Over half of the recipients of *old age assistance* are under age 75; but so many are living far beyond that age, and life expectancy is so markedly increasing, that this load of very old persons will grow. About three-fourths of the recipients of old age assistance had some kind of health problem at the time of the Survey. Medical care, and hospitalization in particular, is a major problem with the aged.

(2) Of the recipients of *aid to dependent children*, more than three-fourths are children who have their lives before them and should have their needs met skillfully and adequately. The number of persons in this group needing medical attention is not proportionately as high as in old age assistance, but it is clear that medical attention is important in ADC. From internal evidence in the case records, the Survey analysts were convinced that in some cases the social workers had not recorded all they knew about the health of persons in their cases.

(3) Forty-two percent of the persons in *general relief* cases were children, — about half as many as the number of children in ADC families. If anything else were needed to prove the importance of good standards of general relief, it would be supplied by this large proportion of children. Most of the adults in general relief cases were physically incapacitated for regular employment. We strongly suspect that more people in these cases have health problems than the records reveal, because for the most part the general relief records we read were sketchy and gave little information that would help a new social worker on the case to know what were the strengths and weaknesses of individuals might be and what hope there was of rehabilitation. Health information, of the greatest importance in rehabilitation, was lacking in many of the general relief records.

*Economic Standards of Assistance.* The State Department of Public Welfare is required by law to make and periodically revise standard budgets that determine how much assistance shall be paid in OAA and ADC cases. Such budgets are fixed at the lowest amount believed to be compatible with a healthful standard of living. Many, but not all, towns and cities use these budgets for general relief. It was shown above how many children are involved in general relief. When children happen to be in a family where less than the standard budget of the State Department is paid, they are likely to be deprived of food, clothing, shelter or other necessaries of life. They receive "second grade" public assistance. There is no defense for such discrimination.

*Medical Care of Public Welfare Clients.* Several communities still continue the ancient office of "city physician," to whom general relief and ADC patients are expected to turn when sick. A few communities have quite creditable clinics. In 13 of the 18 communities there was free or relatively free choice of physician, but in the other 5 free choice of physician was restricted to OAA clients, for whom it is required by law. As the confidential relationship between patient and physician is a factor in successful treatment, there is no excuse for such discrimination against adults who happen to be under age 65 and against children.

Special attention was paid to the 1947 volume and cost of hospital care in all the towns and cities studied (except one). This part of medical care has unusual importance, because the need for hospital beds by public assistance clients is relatively greater than for the general population and because the public welfare agencies in the communities studied pay only a part of the actual cost of maintaining patients in the hospitals. The data collected and analyzed in our full Public Welfare Division Report are extremely complicated and the specially interested reader is referred to that Report for an understanding of the facts on which our conclusions are based. The following general conclusions are drawn:

For the 17 towns and cities studied under this heading, public welfare agencies in 1947 paid to voluntary and public hospitals the sum of $157,308 for medical care to such agencies' clients which cost those hospitals $285,519. Thus, the hospitals concerned were short in one year $128,212 in caring for public assistance clients. Their mean loss per bed day was: $.07 for OAA patients; $4.09 for ADC patients; and $4.95 for general relief patients.

The law requires that public welfare agencies provide medical care for clients of all kinds, and it authorizes them to pay the cost of such care. The cost of care in a hospital or dispensary of a public assistance client is as much the obligation of the tax-supported public welfare agency as is the cost of

the client's groceries, clothing, rent, etc. Yet in many communities of Greater Boston voluntary hospitals are currently reimbursed for only a small part of such cost. Even under the 1947 legislation allowing the State Department of Public Welfare to reimburse local agencies for hospital care on the basis of $8.00 per day (previously $6.00 per day), less than half the deficit per bed day will be covered — and this only for those cases where the law applies: it will not necessarily have any effect on "settled" general relief cases. For the year 1947, the *net loss* borne by voluntary hospitals in the Greater Boston Area through the failure to reimburse the full cost of public ward care for hospitalized public assistance clients in all categories is conservatively estimated at some $185,000. Obviously the sick public assistance client should get as good hospital care as is available, and just as obviously the public welfare agency ought to pay the actual, not a nominal or part of the cost per day, as it pays for food and shelter.

*Individualization of Persons in the Case.* One of the reasons why the average quality of work with OAA clients is higher than for other forms of assistance is that each OAA case is just one person, whom it is easy for the worker to know and understand. The situation is different with ADC and general relief cases, in each of which there are almost always several people involved. In these latter cases, we found a tendency on the part of workers not to try hard enough to learn all they must know about each person in the case to enable them to do good work with the entire group they are serving. This tendency results in inferior casework. The remedy lies in provision of more professionally trained workers, especially supervisors, who can help workers lacking professional training to understand the importance of individualizing each person in their cases.

*Relationship of Client and Social Worker.* The most important factor in the quality of work with public assistance clients is the quality of relationship established and maintained between social worker and client. It is comparable to the highly prized confidential relationship between patient and physician. We found some workers without professional training who understood this elementary knowledge and skill of the social worker, but generally the cases which had been handled with marked success had had at some point the attention of a professionally trained worker. Our full Report gives a table showing in which of the 18 communities a good relationship between client and worker seemed to be the rule rather than the exception, and vice-versa. Where an unsatisfactory relation prevails as a rule, the community is losing money because constructive work is being done in so few cases. In such communities, the agencies should do something drastic to improve their performances.

*Relations of State Department of Public Welfare to Local Boards of Public Welfare.* At present the primary relations between the State Department and the local boards of public welfare may be listed as follows:

(1) State Department prescribes budgetary standards for old age assistance and aid to dependent children.

(2) State Department receives regular reports of financial and service data and special reports from the local boards;

(3) State Department reimburses the local boards for specified proportions of expenditures for OAA and ADC and for "state" general relief cases (i.e., cases without settlement);

(4) A "fiscal audit" of every case in small local departments is made twice a year, and a sample of cases is read once in two years as an "administrative review" by the appropriate district office of the State Department (for OAA and ADC cases only);

(5) State Department issues State Letters which contain new legislation or interpretation of existing law, rules and/or regulations;

(6) State Department intends to provide local boards and staff with some guidance on methods of serving clients.

All items except (4) and (6) seem to be done well, though there are complaints that the State Department is sometimes slow.

The "fiscal audit" seems to us much too costly for any usefulness which it may have. There would seem to be no good reason of public policy for undertaking to audit all OAA and ADC case records twice a year. Some of the best supervisory work is done by federal governmental agencies, and it is rare that they do 100 percent studies: almost always it is by the method of random sampling, which is much less expensive, disturbs the local office less and is highly reliable. If the audit has value to the State Department in supervision, it should be done on a sampling basis.

Item (6), though an obligation of the State Department, is ineffectively discharged. What is needed most in the local agencies is a long-time plan for staff development. This should include in-service

training and a regular program of educational leave for professional training. The State Department could give invaluable service in this connection, if provided with qualified field representatives.

Another thing which the State Department should do is to publish an annual report which gives not only the dry bones of statistics but some intelligible interpretation by members of the state staff who can write. Few devices would go quite so far toward raising to a common high level the work done by local boards of public welfare as publication by the State Department of Public Welfare of an annual report, ably edited and filled with information in a form which can be grasped by normally intelligent people.

*Recommendations*

The recommendations presented below are based upon a study of public assistance services in the Greater Boston Area and upon what is today considered good public welfare practice. In our full Public Welfare Division Report, we present a brief recapitulation of the argument for each recommendation, citing specifically the statutes to be changed wherever statutory change is called for. For the sake of brevity, these recapitulations are omitted here, but interested persons and committees will find it useful to consult them.

For convenience, the recommendations are divided into two groups: *first,* those requiring legislative action or concerned primarily with State administration; *second,* those concerned primarily with local administration.

First: Recommendations involving legislative action or concerned primarily with State Administration.

*Recommendation 1:* Local boards of public welfare should have policy-making and appellate — rather than administrative — powers and duties.

*Recommendation 2:* The State Department of Public Welfare and the local boards of public welfare should have the responsibility for supervising and administering *all* types of public assistance, including Soldiers' Relief.

*Recommendation 3:* In order to improve the quality of service given to those in need by employed personnel in the public assistance field:

(a) The Civil Service Commission should establish new public welfare classifications, with appropriate salary scales, which specify as qualifications for admission to examination: (1) minimum educational qualifications, and/or (2) professional social work education.

(b) Qualifying experience prescribed for both entry and promotional examinations should be based upon a competent job analysis of the position for which the examination is being held.

(c) In both entry and promotional examinations, the weight given to veteran's service, whether the veteran is disabled or otherwise, should not exceed 5 percent.

(d) In promotional examinations, which should be open to persons with appropriate qualifying experience outside the agency, achievement on the examination should be the determining factor; and the weight given to seniority should not exceed 5 percent.

*Recommendation 4:* Qualifying experience for a field representative of a State District Office should include (1) graduation from college and (2) at least one year of professional education in an accredited school of social work.

*Recommendation 5:* The State Department of Public Welfare should publish an informative annual report and a periodic bulletin.

*Recommendation 6:* Contiguous cities and towns which may practicably constitute units for the administration of local public assistance should be empowered and encouraged on their own initiative to establish a joint department of public welfare, subject to the approval of the State Department of Public Welfare. At the end of a ten-year period and following a study of such cities and towns as have not established joint departments, the State Department should be empowered to take over and administer public assistance in such cities and towns as the Department determines might practicably constitute a unit for the administration of local public assistance, until such time as they establish a joint department of public welfare.

*Recommendation 7:* It should be the policy of the Commonwealth that every public welfare agency should pay the full cost of hospital and dispensary care given to its clients in all types of public assistance; and the Commonwealth should implement this policy to the extent necessary by State funds.

Second: Recommendations concerned primarily with local administration.

*Recommendation 8:* Local boards of public welfare should be constituted, and local public welfare agencies should operate, in accordance with these organizational principles:

(a) The local board of public welfare should be a policy-making and appellate, and not an administrative, body. Its members should serve without compensation, but should be reimbursed for travel expense.
(b) The local board of public welfare should be responsible for all types of public assistance in a community, and special agencies for Old Age Assistance or Veterans' cases should be discontinued.
(c) The local board of public welfare should determine the number of employees in each classification required for efficient service by a careful analysis of the caseload and the working hours.
(d) Each local board of public welfare should appoint a director — rather than an agent — who should be its chief executive officer.
(e) The eligibility of clients should be determined by the professional staff of the local public welfare agency.
(f) Local public welfare agencies employing three or more workers should hold regular weekly or bi-weekly meetings of the staff, for which programs raising interesting and administratively useful issues should be planned by members of the staff in rotation.
(g) Each local public welfare agency should develop a definite plan for staff development, including reading the current literature of the field, attending appropriate conferences, in-service training, educational leave, etc.

*Recommendation 9:* The relations between local boards of public welfare and their clients should be founded upon these principles:

(a) There should be the same standard of assistance for general relief cases, old age assistance cases, aid to dependent children cases, and veterans' relief cases.
(b) Every social worker should carry some cases of old age assistance, aid to dependent children, and general relief in order to prevent duplicate visiting to a family, to allow most efficient use of supervisors, and to broaden the experience and increase the competence of the social worker.
(c) A good working relation should be established between the social worker and each person in every case: with all adults, if more than one, and with all children. The social worker should get enough information and spend enough time with each person in a case to know that person as an individual and to understand his potentiality for independence, social usefulness, and — especially in the case of children — growth.
(d) More emphasis should be placed upon the recording of facts and the evaluation of facts in the case records; to the end that a new social worker taking over a case should be able to receive from the records all necessary data for effective assistance. The social worker should clear each case with the Social Service Index; and should find out the nature of the client's contacts with other agencies and summarize the pertinent facts for the case record.
(e) More attention should be given to health problems of clients and to provision of medical care for sick clients.

*Recommendation 10:* All members of the staff of a local public welfare agency should know what other social and health agencies exist in the community, and, where appropriate, should seek the cooperation of such agencies on a case which would benefit through participation of other private or public agencies.

*Recommendation 11:* In order to reduce hospital costs to boards of public welfare, and to free more beds for acute cases, local public welfare agencies and the State Department of Public Welfare should undertake cooperative plans with hospitals to reduce the time of patients in general hospitals to a minimum by transferring patients at the earliest possible date to their own homes, with visits from nurses and physicians, or to a nursing home.

## B. Other Major Individual Services

### *1. Family Casework Services*

In the field of voluntary effort, family agencies carry the brunt of individual services to families, children and adults. Theirs is the basic service, the most central, the most inclusive. Theirs is also the least specialized service, because their typical client is the family unit with all its members, whereas other agencies rendering individual services tend to concentrate on one or more groups within a family, like children, juvenile offenders, elderly people, etc. Family agencies have great need of these more specialized agencies, as the specialized agencies have great need of family agencies; the

whole network of agencies offering individual services should make up a complete, inter-dependent and carefully balanced team of services, bringing to distressed people not only the best that the science and art of social work, but the best that modern science in related fields, can offer. In that team, family service is at once the core and the binder that holds all the parts together.

In our endeavor to suggest a rational, effective and economical *structure* of these voluntary individual services, it is therefore only natural that we should begin with family agencies. If the central core of family service can be put into a sound and workable form, it will be easier to introduce similar order into the more highly specialized services, and to relate them logically both to this central core and to each other.

*Non-Sectarian Family Agencies*

Certainly there is little that is rational or economical about the present structure of non-sectarian family agencies in Greater Boston; as is evident from a glance at Table 1.

TABLE 1

A COMPARISON OF FINANCIAL, STAFF AND CASELOAD FACTORS IN 14 NON-SECTARIAN FAMILY AGENCIES IN GREATER BOSTON FOR 1947

(Listed in Order of Caseload)

| AGENCY | Total Expenditures | Community Fund Payment | Full-time Staff 1/1/48 | | | Caseload | Amount of Relief Paid | Population[a] or Area Served |
|---|---|---|---|---|---|---|---|---|
| | | | Professional | | Clerical | | | |
| | | | Admin. and Supvy. | Case-worker | | | | |
| 1. Family Society of Greater Boston (operating 14 district offices) | $350,123 | $266,467 | 19 | 28 | 23 | 3,970 | $102,157 | Greater Boston[b] |
| 2. Boston Provident Association (operating 1 district office) | 159,296 | 89,834 | 4 | 9 | 8 | 1,255* | 39,794[c] | Greater Boston[b] |
| 3. Family Society of Cambridge | 44,842 | 34,495 | 2 | 4 | 3 | 513 | 15,475 | 111,124 |
| 4. Family Serv. Bur. of Newton | 34,375 | 33,190 | 2 | 3 | 3 | 348 | 14,561 | 77,257 |
| 5. Family Serv. of Malden | 15,096 | 10,000 | 1 | 2 | 2 | 374 | 3,278 | 59,567 |
| 6. Somerville Family Serv. Ass'n. | 14,685 | 10,161 | 1 | 1 | 1 | 339 | 4,946 | 105,883 |
| 7. Brookline Friendly Society, Family Serv. | 27,825 | 22,203[d] | 1 | 3 | 2 | 332 | 7,899 | 59,940 |
| 8. Waltham Family Serv. League | 10,817 | 7,650[e] | 1 | 0 | 1 | 175 | 4,538 | 43,577 |
| 9. Wellesley Friendly Aid Ass'n. | 28,550[f] | 19,133[d] | 1 | 1 | 1 | 144 | 6,326 | 17,581 |
| 10. Weymouth Family Serv. Society | 7,404 | 7,263 | 1 | 0 | 1 | 112 | 1,772 | 27,597 |
| 11. Belmont Family Serv. | 5,973 | 4,297 | 1 | 0 | 1 | 98 | 1,687 | 28,866 |
| 12. Social Serv. Board of Dedham | 5,762 | 4,300 | 1 | 0 | 0 | 91 | 3,029 | 16,659 |
| 13. Arlington Soc. Serv. League | 5,243 | 5,500 | 1 | 0 | 1 | 61 | 1,968 | 43,515 |
| 14. Social Serv. League of Cohasset | 6,639[g] | 3,943[g] | 1 | 0 | 0 | 19 | 971 | 3,540 |
| TOTALS | $716,630 | $518,436 | 37 | 51 | 47 | 7,831 | $208,401 | xxx |

a State census 1945
b Excluding certain towns with recognized family agencies
c Excludes payments for Homemakers
d Includes Fund payment for Visiting Nurse Service ($4,503 in the case of Brookline Friendly Society)
e From Waltham Community Chest — Received allotment of $14,300 from Greater Boston Community Fund in 1948
f Includes expenditures for Visiting Nurse Service
g Includes Nursing and Nutrition Service
* Includes 436 cases given Homemaker Service only

*General Comment on Table 1*

*Financial Support.* Out of a total 1947 expenditure of $716,630, these 14 non-sectarian family agencies received payments from the Community Fund of $518,436*. In other words, these 14 agencies were dependent upon the Fund for 72.3 percent of their 1947 expenditures. The vital role of the Fund in the provision of non-sectarian family service throughout Greater Boston thus becomes apparent.

Except for services rendered in the Metropolitan Area by the two large agencies located in Municipal Boston, only 12 out of the 54 communities in Metropolitan Boston have non-sectarian family agencies.

*Including payment of $7,650 by the Waltham Community Fund to the Waltham Family Service League, and payments for visiting nurse service to three agencies.

A number of the Metropolitan communities lacking such agencies have a larger population than several of the communities possessing them; and there is no doubt that, if more such agencies were to be established, many communities now without them could show caseloads of the size carried by some of the existing Metropolitan family agencies. But considering the availability of funds for total family casework needs in Greater Boston, it would be unrealistic to consider establishing more family agencies on the assumption that each sizable community is "entitled" to its own family agency.

*Staff and Work Load.* The foregoing discussion is highlighted when one considers the smaller agencies listed in Table 1. Agencies 8, 10, 11, 12, 13 and 14 are so-called "one-man agencies," and their one professional staff member is both executive and caseworker. He is responsible for the entire range of duties involved in running an agency — Board work, public relations, inter-agency work, budget details, etc. — in addition to providing personally all the direct service given by his agency. He can have very little time to keep up with current activities of other agencies and their policies. Resources change frequently, and knowledge of community resources is the backbone of any family agency. Not to be able to keep up with them makes for ineffective service. These six agencies had a total caseload of 556 cases in 1947; their total expenditures were $41,838 and they served an area with a total population of 163,754 persons.

In these six agencies, the whole process of administrative duties is nearly the same for each executive. Each attended many of the same meetings for the same purposes and engaged in similar Board and budget considerations. Most of these executives have expressed concern at their inability to keep up with the manifold duties of administration and direct service to clients, and naturally feel that such service would increase if they had additional caseworkers.

Agencies 6 and 9 are "two-man agencies," and suffer from similar problems. Here we have two agencies with 2 professional persons each; a total caseload of 483 for the year 1947; and a total expenditure of $43,235*. These two agencies with a staff of four carried only 73 fewer cases than the previously mentioned 6 agencies with a staff of 6.

The 8 agencies considered above served 1,039 cases with 10 professional workers, averaging 104 cases a year for each worker, or about 2 new cases a week. Such a record unavoidably raises the issue of minimum operational efficiency.

The totals, under Professional Staff, for all agencies show 37 persons in the administrative and supervisory category and 51 caseworkers — nearly three-fourths as many administrative and supervisory personnel as there are caseworkers. This disproportion is one of the results of the uncoordinated decentralization existing today in Greater Boston. There is also 1 clerical to less than 2 professional workers — again the inevitable result of highly decentralized development.

*Other Variations.* In several items in this Table, there are still other variations which can be attributed to the fact that there may be as many different policies and methods with regard to similar operations as there are different administrations.

The Family Society of Cambridge has a budget of over $44,000 and a caseload of 513. The Family Service of Malden, with a budget of $15,000 has a caseload of 374. The Wellesley Friendly Aid Association has a budget of over $28,500 for its family and visiting nurse services, and a caseload of 144 for family service only, as compared with the Waltham Family Service League with a budget of $10,800 and a caseload of 175. While the Wellesley agency gave over $6,000 in relief to 144 cases, the Malden agency gave a little over $3,000 to 374 cases. On the other hand, the Family Service Bureau of Newton gave over $14,000 to 348 cases.

Caseload variations among these agencies are striking. The Somerville Family Service Association with 2 professional workers carried 339 cases; the Wellesley agency with 2 professional workers, 144 cases, or less than half the number carried in Somerville; the Family Service of Malden with 3 professional workers carried 374 cases; while the Newton agency with 5 professional workers carried 348 cases. We are quite aware that the volume of work of an agency depends upon that agency's definition of its job, its casework practice, its recording, its supervisory practices and many other parts of the job which lend themselves to differences in practice. Considered alone, differences in practice may seem negligible; but their effect upon the total amount of direct service achieved may be as dramatic as the examples above show.

*Summary:* The foregoing analysis is presented as an over-all view of one segment of the voluntary family casework effort in Greater Boston. It serves to illustrate the complexity of the existing pattern. It raises many questions as to the lag in over-all planning and equitable disbursement of Community Fund monies in this particular field. It points up the expensive nature of family casework

*Including expenditures for visiting nurse service of Wellesley Friendly Aid

service and its almost complete dependence upon year-to-year Fund support. It shows tremendous variations which, we believe, are due chiefly to isolated independent operating agencies. These variations cannot be rationally justified on the ground of desirable decentralization or experimentation.

The exact size of an operating unit in family service that assures minimum standards of service and efficiency may be subject to debate. But it cannot today be denied that an agency staffed with one, two, or even three persons, is operating below this minimum. Agencies of this small size are justified only as initial or experimental developments, or where the community just cannot support a larger program. This does not appear to be the case in Greater Boston. But for the zeal, unselfish devotion, and downright and continuous over-work of staff members of these smaller agencies, the cost and inefficiency of their operations as independent units would be more easily recognized.

*The Basic Recommendation*

In our full Report on Family Casework Services, we present a somewhat detailed discussion of each of the 14 non-sectarian agencies appearing in Table 1. No attempt will be made to compress that discussion here. It reveals the Family Society of Greater Boston and the Boston Provident Association, while differing at some points in practice, to have essentially similar purposes in their stated functions; each to have special strengths that should be preserved; both to draw their clients from, and offer their services to, much the same area; and both to be used almost interchangeably by the community. It reveals the family agencies in the Metropolitan Area to be afflicted with many and largely similar problems, betraying a lack of integration of all types of social service throughout the Area — particularly in relation to family casework, child care, public welfare, care of the aged, vocational guidance, and others. That full discussion will be of value, we hope, to committees and other groups who may undertake to put our recommendations into effect; but it is not essential here because our basic recommendation does not rest on a detailed discussion of individual agencies.

Our basic recommendation rests on what we believe to be, when facts are squarely faced, the self-evident proposition that continued maintenance of 14 separate non-sectarian family agencies in Greater Boston is indefensible on any logical grounds. Continuance of these separate agencies would be economically wasteful. Economic waste can perhaps be justified when time is of the essence, as in periods of great emergency, like war; but persistence in economic waste can hardly be justified when an alternative plan is offered that is both less costly and more productive. We believe the alternative plan here presented to have both these advantages.

Our basic recommendation calls for consolidation of the existing non-sectarian family services in Greater Boston into a single Federation for family service that will cover the whole area. We are convinced that such a consolidation, organized, led, administered, and distributed in the manner described below, will assure well-rounded and complete services, of fundamentally sound standards, which will readily and continuously be available on an equal basis to all persons and communities within the Area; services, moreover, that can be administered with maximum production, flexibility, effectiveness and economy. Our proposed Federation should be built around and should take advantage of all needed resources and facilities of existing family agencies, their funds and other assets, their Board leadership and local committees, their staff experience and skills, their program specialties. It would thus preserve and strengthen, rather than diminish, local loyalties. The nature of this Federation is set forth at length in our full Report. What is there said may be summarized here as follows:

*The First Step.* The first and major step should be the merger and consolidation of the Family Society of Greater Boston and the Boston Provident Association, under appropriate statutory or court proceedings to assure the continued use of existing endowment funds of each in the operations of the Federation and the due receipt for use in such operations of legacies made in the future to either.

Merger of these two large and important agencies has been a matter of intermittent discussion for many years. We do not have in mind the conventional merger which these earlier discussions contemplated, involving the usual hazards of a "pyramiding of staff," or of one agency "taking over the other" with the further hazard that the program assets of the smaller might be wiped out. Rather, we see this first step in the creation of a new entity as a dignified and statesmanlike consolidation in fact, conserving the strengths, skills and resources of each as the central core of the new and inclusive Federation.

*The Second Step.* Thereafter, as promptly after the first step as sound practice permits, all existing family agency district offices, and all the other independent non-sectarian family agencies in the Area, should merge and consolidate their facilities, resources and staff, in so far as required, with the proposed Federation and its Social Service Centers, as described below.

*The Social Service Centers.* A single Federation for family service covering all of Greater Boston must of course decentralize its operations and work through branch offices. Because we see these branch offices as intake and referral centers for much more than the services offered by the usual family agency, we propose that they be called "Social Service Centers."

Each Social Service Center should effect the closest possible working relationship with all social agencies in its area, including tax-supported as well as voluntary agencies. Each Center should in fact, therefore, have at hand or on call any family service otherwise available in Municipal Boston or in any other Center; and each Center, particularly in the cities and towns in the Metropolitan Area, should provide, where necessary, certain coordinate services not otherwise provided by other agencies to these areas. The headquarters of the Federation for family service should be the source of such adjunct or special services, unless a service demand or need is such as to warrant full time of one or more workers on the Center staff. Special service facilities are described below, but it may be said here, by way of specific example, that the Social Service Centers should in many instances be a resource and referral channel for many phases of child welfare needs.

Some Centers would be located in Municipal Boston and some in Metropolitan cities or towns. In all instances the Centers should be decentralized operating units of the proposed Federation. For Centers in Boston, the areas of coverage would include, but not necessarily be confined to, neighborhoods in Municipal Boston; and similarly, for specified Metropolitan cities or towns, adjacent communities and areas would be included.

Social Service Centers should act as truly integral operating units of the Federation. They should represent, in fact and on a localized basis, the spirit as well as the completeness of a common pooling of Greater Boston's *total* voluntary resources in this field of social service.

We strongly urge, in keeping with the above, that these Social Service Centers avoid any discrimination as to the residence of any client or person seeking service. The client's own convenience, or freedom of choice in selecting a Service Center, should be the sole determinant of where he receives his service. Only in this way can we ever determine accurately the real merit of decentralization, the relative standards of service and usefulness, or use to fullest capacity our manpower and other resources.

*Location and Coverage of Social Service Centers.* While we think the suggestions that follow are sound and practicable, we realize that factors may arise that will dictate some corrections or variations in the proposals made. We are satisfied, however, that the suggested number of operating service units is adequate in relation to the combined services and resources available, and is the maximum defensible on the basis of good standards of operating efficiency and economy.

The central office of the Federation for family service should, of course, be located in Boston, and presumably at the present site of either the Boston Provident Association or the Family Society of Greater Boston. This office would be the headquarters for specialists and specialized programs, as well as for the over-all supervision, assignment and control of staff, in accordance with the varying demands and needs of the different Social Service Centers. It should be alert to meet the demands and needs of the complete network of decentralized operating Centers. It is these operating Centers which must provide, or procure through referral, for *all* of Greater Boston, *all* of the services needed by applicants.

In view of this central pool of reserve and specialized services, we recommend that one Social Service Center be located at the headquarters office. This would provide services without the necessity of referral, to those who seek help at the headquarters address, as so many do. It would also include coverage for a specified area of Municipal Boston.

The network of Social Service Centers, their locations, and the areas to be served, are recommended as follows:

(1) The areas of Back Bay and Allston-Brighton.
The Social Service Center located at the headquarters of the Federation could well serve these areas. Present needs indicate a relatively modest operating unit. An alternative might be to attach Brighton to Brookline, and Back Bay to the North-West End office.

(2) In the South End and for that area.
There is a reasonable need now in evidence and already being served in this area.

(3) In Warren and for adjacent area.
This area should include Roxbury Crossing. There is presently a combined caseload warranting an operating unit.

(4) In Brookline and for that general area.
This unit might include the Jamaica Plain area, or Jamaica Plain might be covered by the Forest Hills Center. (Clients from Jamaica Plain could go either to Brookline or to Forest Hills.) Such an area would warrant a unit.

(5) In Malden and for additional areas.
This unit should include service coverage for the towns of Medford, Melrose, Stoneham, Wakefield, Winchester, Woburn, and the Readings. There is a reasonable service use to justify this operating unit for the area to be served.

(6) In East Boston and further area designated.
This unit should cover the towns of Revere, Winthrop and Chelsea. There is a reasonable service use to justify this unit.

(7) In the North-West Ends and adjacent areas.
This unit should provide service to Everett and Charlestown. For some persons, the Malden unit may be closer to Everett, and use should follow convenience. The areas combined here for service justify an operating unit.

(8) In Dorchester and for the area inclusive of South Boston and the designated Metropolitan communities.
This unit should provide service to Weymouth, Cohasset, Braintree, Hull, Hingham and Scituate. The area of coverage, plus the cases presently served in the towns mentioned, although small in number, justify this arrangement despite the long distances involved.

(9) In Forest Hills or Hyde Park (with Forest Hills being the preferable location), and further area designated.
The Forest Hills unit or the Brookline unit could absorb service to Jamaica Plain. Forest Hills unit should provide coverage for the Dedham and Norwood areas, and for Canton, Walpole, Westwood, Dover, Medfield, Millis and Sharon. The above plans seem feasible in the light of present service volume.

(10) In Cambridge and as an extension of the area presently served.
This unit should give service to Belmont; to residents of Arlington when more convenient than the Somerville Center; to Watertown, Lexington, Lincoln, Bedford, Concord and Acton. The area of coverage and the current previous caseloads and service to the above named towns justify this plan.

(11) In Somerville and for adjacent area coverage.
This unit should principally serve Arlington, in accordance with the normal and most convenient means of transportation. Likewise, when convenience and means of transportation warrant, this unit should provide services to Woburn, Winchester, Stoneham and Medford — in accordance with the convenience of the client. The current caseload in evidence fully justifies this unit of operation.

(12) In Newton and with extension of area.
This unit should also give service to Wellesley, Waltham, Needham, Natick, Sherborn, Wayland and Sudbury. This area of coverage, and the current caseloads and service to the above named towns, justify this plan.

The above recommendations provide for the establishment of twelve operating units or Social Service Centers (in addition to the central headquarters of the Federation), as against the presently existing twenty-nine operating units — fourteen of which are independent agencies and fifteen of which are district units of the two large agencies (14 of one).

While these recommendations propose the elimination of all presently operating agencies or districts, the recommended location of Social Service Centers in fact replaces or substitutes in areas now served by six of the independent agencies and seven of the district offices.* These Social Service Centers, with alterations and extensions of areas to be served, appear at this time to be fully adequate for carrying on the combined services and professional staff now in effect.

The great advantages of the program here recommended are the wider distribution and improved accessibility of family service, and the ready availability to the Social Service Centers outside of Municipal Boston of a centrally located reservoir of case consultants, psychiatric consultants, opportunities for staff developments, etc.

We realize that a comprehensive plan of redistribution of services will take time. We strongly recommend, however, that, while this is being worked out, immediate steps be taken toward affiliation of family agencies in the Metropolitan Area with the proposed Federation for family service. If this Federation is accomplished rather early, through the consolidation of two or more of the largest and strongest of the family agencies (Boston Provident Association and Family Society of Greater Boston: we hope that the plan's civic statesmanship will equally appeal to the Brookline and Cambridge family agencies), it would be logical to bring other agencies into the plan through affiliation at an early stage. We visualize the possibility of greater demand for services coming particularly from those towns and communities heretofore served casually or inadequately. This is to be expected, and may offer the temptation to create additional small service centers for such areas. We warn against doing this until

*The Boston Provident Association and the Family Society of Greater Boston each have a district office in South Boston and each have a headquarters service unit.

full load over a sustained period of time warrants a readjustment in Social Center areas. Until such readjustment is called for, we suggest that staff from the Social Service Center serving that area be assigned to an arranged branch office of the Center, on a schedule of days and hours appropriate to the needs.

*Provision of Special Services.* The Federation for family service, centrally and through the Social Service Centers, should provide certain services, both general and special, which are adjunct to family casework and counseling. To this end we recommend:

(1) Establishment in the Federation of an information and referral service for the Greater Boston community.

(2) A screening service, staffed if necessary with one or more specialists, which would undertake one or more of the three functions of district service, information and referral, and liaison with other services, in the following coordinate areas of service: Child Guidance, Child Placement, Services to the Aged, Rehabilitation Services, Vocational Counseling, Day Care Services, Psychiatric and Mental Hygiene Services, Medical Social Work Services.

(3) Maintenance of certain established services, such as the Homemaker Service now rendered by the Boston Provident Association. Indeed, we hope this service will be made even more available and useful under the consolidation, in relation to developing needs and as sharper focus develops through use of specialists as suggested.

(4) Extension and further experimentation with the group method of counseling, the first phases of which have been so well undertaken by the Family Society of Greater Boston through its Education for Family Life program.

*Recommendations with reference to a Board of Directors, Social Service Center Policy Boards, Committees, and citizen participation generally:*

No social service agency, no matter how well organized or administered, can remain for long responsive to community needs and desires, unless contributors and lay citizens at large are continuously and actively interested in and responsible for its policy and general management. We therefore very strongly recommend, not only a central Board for the Federation, but local Boards or Committees, for each of the Social Service Centers. In so far as practicable and desirable, such Committees should be established to help shape policy, appraise effectiveness of program, and in other ways represent both the agency and the community, on any normal local political or neighborhood unit basis.

The principle of interlocking or representation should be applied throughout. Every town should know that it has one or more spokesman and who they are. Representation should move from the locality to the Social Service Center Policy Board, and thereafter to the Board of Directors of the new Federation for family service.

These Boards and Committees, at every level, should prove of great value, not only in assuming an alert, responsive and responsible organization of services, but in relation to planning, appropriations and allocations, and in other ways.

*Board of Directors.* While the Board of Directors of the proposed Federation should be determined upon in size, representation and constituency, in accordance with currently recognized standards and criteria for voluntary agency Boards of Directors, we urge that the consolidation of the two (or more) principal family agencies should not constitute an option on all memberships or vacancies on the new Board, until the succeeding conditions have been accomplished.

(1) The Board should provide for a reasonable proportionate representation from the Metropolitan areas.

(2) Initially *all* presently existing independent family agencies in Greater Boston should have membership and representation on the central Board, or vacancies or open memberships for some should be retained.

The implication in the above is that present officers or members of existing independent family agency Boards would be chosen for the nucleus of original membership on the Board of the new Federation. Further, that such designation might coincide with, or be in anticipation of, the merging or consolidation of the independent family agencies with the new Federation.

(3) Local Boards (we suggest "Social Service Center Policy Boards") or Committees should be retained and identified with the Social Service Centers, with representation on the Board of the Federation as recommended above. Many of the existing Boards should be strengthened through the addition of new membership broadly representative of a cross section of the community and of the areas to be served.

(4) Localized town or small community Committees should likewise be retained where they now exist (as Boards or otherwise), and creation of such Committees where there are none should be encouraged.

Definite channels of communication, and lines of authority and responsibility, should be established in order to make this citizen participation as useful and effective as possible. A carefully planned system of citizen participation, with real, not token, sharing in policy formulation, program review and determination, budgeting and allocation, will more than compensate for the time and effort put into this development.

*Sectarian Family Agencies*

*Catholic Agencies*

Four major Catholic agencies are engaged in family service in Greater Boston — the three separate Catholic Charitable Bureaus of Boston, Cambridge and Somerville, and the Society of St. Vincent de Paul.

The Charitable Bureaus are agencies of the Roman Catholic Church. Their authority is vested in the Archbishop of Boston. The determination of the areas within which, and the methods through which, they shall work, are influenced by the doctrines and policies of the Church. The three Bureaus are not administratively integrated, except that the Cambridge and Somerville Bureaus send to the Boston Bureau various statistical reports for consolidation for the Archdiocese. They are staffed with professionally trained workers.

The Society of St. Vincent de Paul is the local unit of an international Catholic organization which operates throughout the world. The Society's central office has only one person professionally trained in social work. The Society's family service and child care work is carried on through personal visits by the lay members of the Conferences, visiting in pairs, to families in need of service. Emergency material relief is granted or other appropriate action is taken on the first call. The visitors report their findings and action at the next weekly meeting of the Conference, at which all members in a case conference give consideration to all aspects of the problem and advise the visitors as to further procedure. Weekly or more frequent home visits follow, with weekly reports to the Conference until the problems are corrected or the case is referred to another agency deemed more suitable for action in the case.

The organizational structure of the Society, which is identical throughout the world, is expressly provided in the Articles of the Society's General Regulations. It is the "special object" of the Society that its members themselves shall "visit poor families in their homes"; not only for the alleviation of suffering, but also for the salvation of souls. The work of the Society cannot be appraised without full understanding of this underlying spiritual philosophy.

The liaison which exists between the Bureaus and the Society results in a form of reciprocal service. There are times when the Bureaus refer family cases requiring assistance to the Society — in the case of certain Bureaus such referral may arise from inadequacy of funds. Because of the known relief service which the Society offers, as against the limitations (in staff and funds) of the Bureaus, there are occasions when community agencies refer cases to the Society which otherwise might have been referred to the Bureaus. On the other hand, the Society on occasion refers to the Bureaus certain cases which in its judgment require special skills and services; as, for example, certain difficult family problems, cases involving unmarried mothers, maternity problems, adoptions, and child placement.

Counseling on personal problems, and the efficient and effective use of relief funds, is a difficult task. The use of technically qualified and skilled staff and supervision ensures both good services and an economical and effective use of funds. For this reason, it is our opinion, based objectively on modern standards of social work, that Community Fund money should be applied to family and children's agencies which operate on the basis of accepted modern standards of personnel and work. The following recommendations are intended to point the way to the provision of better quality service, to the elimination of duplication, to the realization of economies. It is not within our province to appraise the spiritual and doctrinal factors which are involved, and we make no attempt to do so; leaving these factors to be interpreted by the authority of the Church.

Subject to the foregoing, we believe:

(1) In the long run, the best result will be achieved, in the Catholic field of family service and child care, by strengthening the Catholic Charitable Bureaus, through

a. Consolidation of the three Catholic Charitable Bureaus under one administrative — as they are under one ecclesiastical — direction. The three present offices should be maintained; the areas of coverage being redefined between them.

b. Adequate financial support from both ecclesiastical and Community Fund sources, assuring employment of necessary qualified staff and comparable services.

(2) Consolidation of the District Offices now maintained by the Boston Bureau should be brought about in conformity with economically operating units and known needs and requests for services.

(3) It is recommended that all Catholic charitable agencies review current practices and policies with regard to services and financial assistance with a view to making full use of tax-supported agencies where these items are or should be a tax-supported responsibility.

(4) The Catholic Charitable Bureaus and the Society of St. Vincent de Paul should more clearly differentiate those areas of service within which each has a unique contribution to make in a total spiritual and welfare concern for people. This would enable each to use those strengths and skills which are most appropriate to the need or problem encountered. By such a definition of services, the Bureaus and the Society will henceforth be even better able to coordinate their programs and relationships towards maximum use of the facilities of each. The Society could well use its great prestige and strong and interested lay membership to support and strengthen the work of all Catholic agencies and institutions, as was recently pointed out by Archbishop Cushing at the Society's Annual National Meeting.

(5) With further reference to our recommendations under (1) a., the Catholic Charitable Bureau and its operating units should serve as Catholic welfare centers for family and coordinate services where these services are not otherwise available. These centers should likewise serve as information, liaison, and referral centers for their own constituents, including institutions and agencies.

(6) When the above recommendation as to the consolidation of the Catholic Charitable Bureaus has been approved, and in keeping with similar recommendations with reference to the non-sectarian family agencies, we recommend that the Community Fund appropriation for Catholic family services, including relief, be made to the newly consolidated Catholic Charitable Bureau.

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*The Executive Committee of the Survey dissents in part from Recommendation (6) for the following reasons:*

"*1. The Executive Committee approves of the strengthening and consolidation of the Catholic Charitable Bureaus, as outlined in this Report, and of the necessary financial support by the Community Fund to effect the Report's recommendations in that regard.*

"*2. The Executive Committee believes in the validity and worth of the services rendered to the community by the Society of St. Vincent de Paul. It recognizes the enthusiasm and personal interest which animate the members of the Society, and considers their lay contribution to family service an asset of the community. Accordingly, it is the Executive Committee's considered opinion that the Society of St. Vincent de Paul should continue to receive financial assistance from the Community Fund.*"

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*Jewish Family and Children's Service*

This agency, which is not a Community Fund agency, but is supported through the Associated Jewish Philanthropies, was studied chiefly from the standpoint of its relationship with other agencies in the community.

The agency operates a main office and 3 district offices — one in Dorchester, one in Roxbury, and one in Chelsea. The greater part of the Jewish residents in Greater Boston live in Municipal Boston and of the population there make up a very small percentage of the total. The agency, which serves Jewish clients in the family and child care fields, is operated as an integral unit, and its professional standards and the qualifications of its workers rank high. The agency provides, in addition to its family work and children's service, a consultation service to the aged, a youth service, a study home for problem children, and a camp program.

The agency uses the Homemaker Service of the Boston Provident Association, and has found it to be quite satisfactory. Several years ago, the agency had its own Homemaker Service program. There has been some discussion of starting it again. The agency is aware, however, of the cost and duplication that would be involved in setting up another such service in the city.

There exists in Greater Boston a desire for clarification of the question as to whether or not Jewish families seeking assistance from other non-sectarian family agencies should always be referred to this Jewish agency.

We Recommend that (1) this agency should be an active participant through the Greater Boston Community Council in all policy and planning, with particular reference to coordinating its activities with non-sectarian and other programs, as a means of guarding against unnecessary extension or duplication of services; i.e., specifically, that this agency should not undertake a separate Homemaker Service at this time; (2) the intake policy of this agency should be based on the essential principle of freedom of choice on the part of the client; and (3) to the greatest extent possible, Jewish families seeking services which this agency is capable of rendering, should be referred to it.

*Multifunction Agencies Providing Family Casework Services*

*The International Institute of Boston, Inc.*

"The purpose of the International Institute is to assist newcomers to the United States in their adjustment and better integration into the community and to cultivate understanding and appreciation between all members of the community . . . "

The functions of the Institute's casework staff are to provide assistance in technical matters related to immigration, naturalization, and related social work problems; and to provide a general family casework service for cases where foreign-ness constitutes a complicating factor.

Case reading and statements of the supervisor confirmed the impression that a large part of the work now done by the staff is the same as that done by the two principal family agencies. We think much of the caseload is made up of persons not very different from persons of foreign descent which any good family agency recognizes at its proper concern. The special skills of language and technical information which the Institute's casework staff possess seem to us the only justification for maintaining this staff, and then only where the problems met are such as to involve a language handicap or technical problems stemming from immigration.

One could easily duplicate family casework services in any agency in the community — in settlements, medical social service departments, child guidance clinics, the courts, etc. — if one were to extend the specialized functions of these agencies into a general casework program. Certainly there are many clients in family agencies who do not speak English too well or whose problems derive from cultural differences. An appreciation and understanding of these factors is a part of every caseworker's training in learning the causative factors of maladjustment.

Several cases read illustrated both the technical assistance and the kind of treatment given by the agency. These cases were selected by the supervisor as representative of the agency's work. We could see no reason why some of these cases should not be under the care of a family agency. Others involving technical assistance were clearly within the Institute's primary purpose.

We Recommend that (1) The International Institute should confine the services of its casework staff —

(a) to cases requiring technical knowledge and skill in the areas of immigration, naturalization, or any other matters directly concerned with such legal matters, supplementing the work of the State Division of Americanization and Immigration; and

(b) to persons who are seriously handicapped in their adjustment by language difficulties and who cannot, for this reason, be served in a family agency.

(2) The skills and training of its casework staff should be used to assist in carrying out Recommendation 33 of the Recreation and Group Work Division Report, reading as follows: "The International Institute should discontinue its present recreation and group work program, and the appropriate Division of the Greater Boston Community Council should assist in the development of a new program based upon the following:

(a) Aid individuals and groups seriously handicapped by virtue of language difficulties to become affiliated with recreation and group work programs in the areas and communities of Greater Boston in which these individuals and groups reside;

(b) Aid the agencies directing these programs in understanding the needs of these individuals and groups and assist in the organization and direction of programs which meet these needs."

(3) This agency should continue to make available to all other agencies the special skills and training of its casework staff.

(4) Until this agency has screened the caseload now being handled by its workers to retain the type of cases included in Recommendation (1), it should not employ additional workers. Once the caseload has been screened to exclude all cases properly belonging to a family or other casework agency, its present staff should be adequate if not in excess of its needs.

*The Executive Committee of the Survey dissents in part from these Recommendations for the following reasons:*

*"1. The Executive Committee supports the substance of the four Recommendations relative to the International Institute. It is aware of the Institute's fine service in the past and of the accentuation of the agency's work at this time through immigration of Displaced Persons.*

*"2. The Executive Committee believes, however, that — in addition to continuing to make available to all other agencies the special skills and training of its casework staff (Recommendation 3) — the Institute should progressively move to the goal of affiliating and consolidating its casework with that of family or other casework agencies."*

*Morgan Memorial* (Family Service Bureau)

The Family Service Bureau of Morgan Memorial as now set up has several distinct functions. It does the intake for the Day Nursery Unit, the Seavey Settlement, and the Sheltered Workshops, and works with individuals and families who come in from the surrounding neighborhood for emergency relief or in relation to some Morgan Memorial program. It also accepts referrals (mostly for relief) from the public welfare department, hospitals, and other voluntary agencies.

There does not seem to be any justification for a separate Family Service Bureau in Morgan Memorial. The Goodwill Industries, Hayden Goodwill Inn, the Youth and Children's Center, Eliza Henry Home and Day Nursery are self-sufficient units, and such casework services as may be required for the Sheltered Workshops should be provided within that program. (See Voluntary Casework Division Report, Services to Homeless and Unattached, regarding Seavey Settlement.) Most of these units select their own clients and there does not seem to be any reason why all could not do so. There is, furthermore, direct duplication with the established family agencies in such cases as are carried by the Family Service Bureau that do not have any connection with its above-mentioned departments. At the cost of a small part of the Family Service Bureau's budget, it would appear that this agency could buy any casework consultation needed.

We Recommend that (1) the Family Service Bureau of Morgan Memorial be discontinued as a separate department. However, the need is recognized of casework within the Sheltered Workshop program; and the unit doing such casework may also serve as the central registry for Morgan Memorial.

(2) Where necessary to make referrals to community agencies of clients known to the various Morgan Memorial units, this can be accomplished by referrals directly from such units, or the Morgan Memorial central registry.

*The American Red Cross* (Home Service)

Our interest in this agency was directed chiefly to its relationships with other agencies. The Red Cross is not a Fund agency and its basic policies are determined on a national level.

The Home Service of the Red Cross is concerned with the families of persons on active military service, a definable area of service within which there should be no duplication. Its Home Service is also concerned with veterans and their dependents, an area which World War II has expanded to tremendous proportions.

It is in this second area that the Red Cross may undertake casework service beyond the veteran's "claim." A definition of "service-connected," by which the Red Cross has attempted to clarify its area of work as different from that of the regular family agency, has been used. Personal and emotional problems of a veteran which are, by legal definition, actually service-connected, fall within the province of the Veterans' Administration, which has neuropsychiatric and general casework services available to veterans with service-connected problems. At the same time, any good family casework agency can provide casework services to a veteran or his family, whether his problems are service-connected or not.

The Home Service Department of the Metropolitan Chapter seems to have worked out a fairly satisfactory definition of its area of responsibility. This unit, like other chapters of the Red Cross in the Greater Boston Area, is relatively autonomous. General policy made on a national level could lead to considerable duplication of work with other voluntary tax-supported agencies were it not that policies can be interpreted locally with considerable latitude.

We Recommend that the Greater Boston Community Council continue its present efforts, cooperatively with the Red Cross and in recognition of Red Cross national policies, to work out home service practices with the Red Cross in all Chapters within the Greater Boston Area, with a view to the elimination of duplication and overlapping at the expense of voluntary givers.

## 2. *Child Care*

### *(a) Division of Child Guardianship (State Department of Public Welfare)*

*Major Functions of the Division*

The Division of Child Guardianship of the State Department of Public Welfare has four major functions:

1. To place neglected, dependent and delinquent children in foster homes;
2. To carry on a program of child welfare services under the Social Security Act;
3. To investigate petitions for adoptions presented to the Probate Courts; and
4. To license infant boarding homes.

In addition, Division representatives attend juvenile sessions of the District Courts in the interest of neglected, delinquent and wayward children; approve the corporate guardianship of minor children with some exceptions; are responsible for carrying out the law regarding admission of children coming into the State for care by persons not related to them by blood or marriage; for out-of-town inquiries on children; and for visiting annually about 1,400 children who have been placed in foster care by local welfare officers. In addition to its main office in the State House, the Division has District offices in Brockton, Lawrence, New Bedford and Springfield; and a fifth District office was being set up in Worcester at the time of this study.

The Director of the Division is responsible to the Commissioner of Public Welfare. There is an advisory committee of seven members, mostly executive directors of children's voluntary agencies. This is an unofficial committee and has no standing in law.

*Confusion in Legal Definitions*

The laws relating to the care of dependent and neglected children are antiquated and inadequate. There is no clear-cut definition of a "dependent" child. In regard to "neglected" children, there is conflict in the laws (but not in practice) between the responsibilities of courts and those of the departments of public welfare.

In general, children accepted as "dependents" are: orphans who have no relatives to provide care; part orphans with the surviving parent unable to provide care; children with both parents incapacitated mentally, physically or emotionally and without other relatives to provide care; illegitimate children whose mothers cannot care for them; children whose situation borders on neglect but whose neglect cannot be proved; mental defectives; prepsychotic and psychotic children; and orthopedic cases. A "neglected" child is a child under 16 years of age, who, "by reason of orphanage or of neglect, crime, cruelty, insanity, drunkenness or other vice of its parents, is growing up without education or salutary control, or without proper physical care, in circumstances exposing him to lead an idle and dissolute life, or is dependent on public charity." This definition is too broad, for it includes "dependency". And the definitions of both categories include orphanage.

Dependent children are *referred* to the Division of Child Guardianship by parents, guardians, local welfare officials or other interested persons. Neglected children are *committed* to the Division by the Courts.

*Preponderance of Neglect Cases*

The fact that a large majority of cases handled by the Division are neglect cases, and hence are court commitments which the Division must accept, raises questions in regard to legal definitions and payment for cases. The State bears the full cost of the care of committed "neglected" children, but is reimbursed by towns and cities for the care of settled "dependent" children accepted by the Division. The confusing legal definitions of dependency and neglect, combined with the present method of local and State financing of the two classes, accounts in some measure for the large number of neglect cases.

If departments of public welfare in towns and cities were charged with financial responsibility for all children needing care in their jurisdictions, the majority of children now brought before the courts in Massachusetts and committed as "neglected" children could be placed in foster care as dependents and thus spared the shock and harrowing experiences they must go through in court action.

*Staff Problems*

At the time of this study, the professional staff consisted of a director, an assistant director and 153 supervisors, headworkers and caseworkers, handling a total caseload of 6,132 children and carrying out the other functions of the Division as mentioned under items 2, 3 and 4 above. Caseloads in every unit are too high. Caseworkers responsible for placing children for foster care have average caseloads

of 85; in the intake unit, caseloads average 150 cases per intake worker per year; and in the adoption investigation unit the average number of adoptions per worker is 140. The ratio of supervising personnel to workers in both the Boston and District offices is one to 7, an accepted ratio.

Fifteen of the 153 workers are graduates of a school of social work and nineteen others are now taking courses in school. There are no minimum educational requirements in Civil Service for these positions, but in a new social workers examination to be held, requirements are two years of experience or graduation from a recognized university.

There is one home-finding unit in the Boston Office, consisting of a supervisor and three workers, which is responsible for finding homes, for temporary care, for infants and for children with special problems. There is also one home-finder in each District office. For all other children the social worker responsible for supervision of children has to find homes. These workers now carry a caseload of 85 per worker and therefore cannot do the intensive work required to find and develop new homes. In February, 1948, there were 2090 boarding homes in use, but according to the assistant director of the Division 500 new homes were needed. Four children are considered a desirable maximum for a permanent home; five or more are considered overcrowding. The Division estimated that 400 children in Boston were living in overcrowded homes at the time of the Survey.

To evaluate the quality of supervision of children placed in foster care 93 cases were read — 50 cases of "neglect", and 43 cases of "dependency". Two hundred thirty children were involved in these 93 cases. It was found that children were placed and replaced in homes in what seemed to be far too many instances. The records of the 43 "dependent" cases showed that after acceptance the workers did not try to find any other solution than placement of the child outside his home. Many times replacement was used instead of joint treatment of the child by foster parents and the caseworker. The records do not reveal understanding by many workers of the emotional needs of children in placement. Records also showed little evidence of casework with the child's own parents in an effort either to return him to his own home or to maintain parent-child relationships while he was in foster care.

It is obvious that even trained workers carrying the loads indicated above have inadequate time to plan for rehabilitation of families in all the cases where it might be achieved. Yet prevention of family disintegration and the dependency of children should be an important part of a caseworker's job.

*Board Rates for Foster Home Care*

Current board rates range from $10.00 a week for infants up to two years old, to $7.50 a week for children from five to nine years old. Fifty cents additional a week is allowed for the care of mentally defective children. Board rates include cost of food, recreation, allowances and incidentals, but do not include clothing (for which there is a special allowance), or medical care, dental care, school supplies or transportation to a hospital or doctor's office (which are paid for separately). Special rates are paid in individual cases for problem children and for those presenting health problems. There is no attempt to include a service fee for the boarding mother.

The bearing of these low rates, which are the prevailing rates for both voluntary and public agencies in the community, on the care children receive is commented on below.

*Too many Replacements*

More than one-third of the children in the 93 records read had been transferred from one home to another two or three times; 23 percent had been transferred from four to fifteen times. Replacements are a very serious experience for a child, and are costly to the Division. Many of the children under care have already suffered deprivation and neglect in their own homes and so have a serious feeling of lack of security. Placement in a foster home adds to their lack of security, and each replacement is a further threat to a satisfactory adjustment. Our study of records revealed several reasons for the frequency with which children were shifted from one home to another.

Home-finding, including the study and evaluating of boarding homes, cannot be thoroughly done because of lack of staff and lack of trained staff. Homes frequently are accepted for foster care after a single visit in which only one parent is seen. Boarding home rates, as already noted, are too low to attract and hold homes of the quality needed by children under care.

The inability of caseworkers, carrying high caseloads and without sufficient training or experience, to understand and deal with the behavior problems of emotionally disturbed children is an equally important factor. Too frequently a transfer to another boarding home was resorted to instead of an attempt to help the boarding parent to understand, accept and deal with a disturbed, unhappy child. Some workers seemed to understand the significance of a child's behavior and the difficulty of maintaining a relationship between a child in placement, his natural parents and his foster parents.

*Adoptions*

Very few children under the care of the Division are placed by it for adoption in spite of the fact that approximately one-third of its entire caseload consists of illegitimate children and foundlings — a group potentially eligible for adoption. More than 2000 illegitimate children and foundlings per year are normally under the care of the Division, yet only about 60 adoptions a year are completed, including children adopted by their foster parents. Study of the records showed that little attention was given by workers to the possibility of adoption, and most of them discouraged the idea.

At the present time the Division's adoption investigation unit, which investigates independent placements for the Courts, is too understaffed to provide the service required by law. As a result, some Courts have waived the required investigations and permit adoption decrees before complete investigation of the adoption plan is made. An adequate adoption program would demand additional well qualified personnel.

Amendments proposed to the Legislature in 1948 would, if passed, add desirable strength to the adoption laws. The major points covered in these amendments are as follows:

(a) the age at which a child can legally consent to his own adoption is lowered from 14 to 12 years;
(b) consent to adoption made prior to the birth of a child or within 30 days after his birth is invalid;
(c) religious protection laws are strengthened by insuring that a child be placed with persons of the same religious faith as his parent, or of his own faith, according to circumstances;
(d) reports to the Court on investigations of adoptions are required within a specified period;
(e) the length of time a child must reside in an adoption home before a decree is granted is extended from six months to a year;
(f) the Department of Public Welfare is required to keep a record of adoptions.

No proposal has yet been made, however, for removing a child from an unsuitable home after denial of a petition to adopt. And there is still need for a law making it a penal offence to give or take money for placement of a child for adoption by any other than a licensed agency.

If the Massachusetts laws covering adoption were amended in conformity with the above proposals, they would be good, but the Division would have to be strengthened in staff and budget to carry them out. From July 1, 1946, to June 30, 1947, 2914 petitions for adoption were referred by the Courts to the Division for investigation. One hundred forty-eight were withdrawn; 1874 were investigated and reported on; *892 were not investigated.* The trouble lies in the fact that the adoption investigation unit, although well supervised, is even now understaffed and the majority of its social workers are untrained.

*Medical and Dental care*

Medical and dental care of children in the charge of the Division appears to be good. The Division pays for medical and dental care. Amounts are fixed but special care involving extra expense may be arranged by the supervisor. Foster parents are allowed to make a choice of doctors and dentists and hospitals, although free clinics are to be used when possible. There are no periodic physical examinations for children of school age except those provided by public schools, and even in the case of these examinations there is no frequent periodic review of reports by a pediatrician.

The majority of case records that were read, showed good attention to the children's medical needs. Recording on this point was more consistently good than on any other.

*Group Care*

Lack of facilities for group care of adolescents and children with special problems is a real handicap to the Division of Child Guardianship. The Division conducts no institution of its own for children, and because of legal prohibitions makes little use of group care facilities. Of 6132 children under care on December 31, 1947, only 252 were in medical and other institutions.

Group care is known to be preferable for certain children (e.g. large families that cannot be accommodated in one boarding home, many adolescents, and seriously disturbed or neglected children). Yet the Division, because of the law, is placing great emphasis on boarding home care to the exclusion of group care. If it is not possible for the State to operate its own institutions for the care of small groups, the law should be changed to permit more extensive use of private institutions with good programs. Such care should be fairly paid for by the State.

*Need for Child Guidance Clinic*

It is the policy of the Division to secure psychological and psychiatric examinations for children when they are needed, but facilities are so limited and waiting lists so long that not much of this service is available.

There is no doubt that many of the children have had seriously damaging experiences before they came to the Division and could profit by psychiatric treatment. It takes a reasonably well trained staff, however, to make sure that the full value of psychiatric service is realized. If and when the Division can attract more trained workers or provide in-service training for more of its staff, and when caseloads can be reduced to a more workable size, it would be desirable and profitable to the Division to have its own child guidance clinic.

*Recommendations*

In order that the Division may more nearly carry out its function of meeting the basic needs of children under its care, the following proposals are made:

We Recommend — That the law be amended to provide new definitions of "dependent child" and "neglected child". These definitions should be so worded that children can be accepted for foster care as dependents for social and emotional reasons and not solely because they are indigent. The definition of "neglect" should require court action only when parents refuse voluntary cooperation with public welfare officials.

Because the method of financing child care through local support of "dependent" children and State support of "neglected" children results in exposing a high percentage of the children to court action for neglect:

We Recommend — That a new system of paying for children under care by the Division of Child Guardianship should be established. Such new system could require local communities to reimburse the State up to a stated amount (e.g., 40 percent) for the direct care of both "dependent" and "neglected" children, with the State bearing a large part or the full cost of administering the program.

Because an enlarged home-finding unit would be able to find more and better boarding homes, cut down the stay of children in temporary homes and help to reduce the number of replacements in permanent boarding homes, and because increased staff in the adoption investigation unit would enable the Division to keep up with investigations for adoptions requested by the Probate Courts:

We Recommend — That immediate consideration should be given to the following staff requirements of the Division of Child Guardianship: (a) The staff should be maintained on the basis of one supervisor for every seven to ten caseworkers, and enough caseworkers to insure a caseload for each of not more than 55; (b) Educational requirements in Civil Service should be raised to specify college graduation, or its equivalent by training or experience, for beginning social work positions and professional training or experience for positions at higher levels in the Division of Child Guardianship; (c) Training units should be enlarged by two more qualified supervisors to make possible more in-service training of the present staff.

Because some children are better cared for in groups than in a single-family setting:

We Recommend — That the Division of Child Guardianship should have available facilities for the care of small groups of children who would benefit from group care. Either it should itself maintain such facilities or the law should be changed so as to permit the Division to purchase group care from private agencies at the prevailing rate.

Because many children under care by the Division have had seriously damaging experiences and are in need of psychiatric treatment:

We Recommend — That the Division of Child Guardianship, in cooperation with the State Department of Mental Health should provide child guidance clinics for the children under its care for diagnosis, consultation, and if possible for treatment.

## *(b) Voluntary Child Care Services*

Voluntary Child Care Services in Greater Boston, as elsewhere, fall naturally into the following major classifications:

Foster boarding care
Protective care and detention
Group care facilities for study and treatment
Child guidance facilities
Services related to children — i.e., unmarried mothers, adoptions, family casework, etc.

In each of these fields the Survey found much excellent work and a vast amount of interest and concern. We have no wish to minimize the value of all that has been and is being done. But looking at the services as a whole, we found too great a variety of agency patterns, with inequitable distribution, duplication,

overlapping, gaps in service, and lack of accessibility to those needing service. The evidence is convincing that individual agencies have been attempting valiantly to meet partial community needs, but that there has been too little community planning to insure that the agencies as a group mobilize and distribute their services in such manner as to provide the most complete, effective and economical service for all children needing service. The following discussion and recommendations, dealing only with the major voluntary agencies in the child care field, are designed to construct a basic pattern that will bring such service about.

*Beginning at the Center*

A general child care committee should be established at once in the Greater Boston Community Council. This committee should have as its purpose the continuous integration of the five fields of child care listed above. It should promote cooperation and coordination of services; recommend areas of service needing curtailment, expansion, realignment or change in emphasis, or requiring new services. Its membership should include representation from each of the five fields named, from Metropolitan cities and towns through the proposed Social Service Centers, and from the proposed Federation for family services. It should be particularly concerned to promote a close relation between family services and child care services, accessibility of services to persons especially in the Metropolitan Area, and provision of special services (e.g., homemaker service, vocational counseling, child guidance, rehabilitation services) through the Federation for family services.

We Recommend the prompt organization within the Greater Boston Community Council of a general child care committee with responsibility to promote the continuous integration of all child care and related services in Greater Boston.

*Non-Sectarian*

Underlying our specific proposals for strengthening non-sectarian child care services is the conviction that one of the major non-sectarian agencies should be recognized as the community's primary and leading resource in each of the five fields into which we have divided child care services. Such agencies should, so far as possible, strip themselves of all corollary functions and concentrate on their major function. This step will provide a sound structure of services for the community, and will make possible a logical and economical re-alignment of existing agencies and services. It will clarify agency functions. It will make easier a pooling of existing specialized skills and facilities, so that the added concentration and strength achieved in each field will be accessible to agencies and persons in other fields throughout the Area. It will bring greater strength to the total operation in standards of work and administration. It will permit full use and deployment of personnel. It will increase accountability; both in self-appraisal and in appraisal by the community at large, it will give greater assurance that Greater Boston has, or can get, the kind of child care services it needs and wants. It will enable the services to be more readily understood by their supporting constituency — surely a factor of prime importance.

To this end, we make the recommendations that appear below. In this Summary Report, we will not set forth the full details about the agencies dealt with that are found in our full Reports — the variety of services each agency offers, its area of service, the size and nature of its staff, its volume of work, its expenditures and the amount of support it receives from the Greater Boston Community Fund. Working committees concerned with putting these recommendations into effect will need all this and much more information. Here we are concerned only with making clear the nature and form of the underlying structure we propose. Once again let it be said that we are dealing only with the Area's major non-sectarian child care agencies.

(1) *Foster Boarding Care*

The Children's Aid Association has a key position in the field of children's services in Greater Boston and can exert a powerful influence for improvement in its proper sphere. In its attempt to meet the demands made upon it, or to fill the gaps in service it has found in the community, it has extended its activities beyond its capacity to serve. To assist it in performing its best service, and in making a maximum contribution to the child care field in Greater Boston:

We Recommend that (1) the Children's Aid Association should strengthen and expand its foster care service, eliminating all special services not directly related thereto; (2) in addition to becoming the community's primary resource for foster boarding care, it should become the representative child care information and referral center in the child care field; (3) it should merge and consolidate with the Avon Home as hereinafter recommended for that agency; (4) its Neighborhood Club Department should be dealt with in accordance with Recommendation 61 of the Recreation and Group Work

Division Report; and (5) its detention shelters should, as promptly as possible, be transferred to the Youth Service Board, which is to establish such shelters during the current year pursuant to c. 542, Acts of 1948.

The Avon Home is carrying on a good service, in a restricted area and with limited resources. Its program is similar to that of the Children's Aid Association, with which it enjoys excellent cooperative relationships. In pursuance of our basic objective in the non-sectarian child care field:

We Recommend that, prior to 1950 the Avon Home merge and consolidate with the Children's Aid Association, centralizing its operations at the facilities of the Association and disposing of its physical properties.

The Children's Mission to Children is engaged in a highly valuable program of foster care, dealing principally with children having medical problems. We think its service should be continued, but that it can be made more effective if carried on in conjunction with a center of medical care. Therefore

We Recommend that (1) the Children's Mission to Children should devote its complete resources to the care of sick and convalescent children, eliminating all work not in keeping therewith; and (2) the Children's Mission to Children should merge or affiliate with the Children's Hospital.

(2) *Protective Care and Detention*

Examination of the services now provided by voluntary agencies in the protective field shows that:

a. The services provided fall into 6 main categories:
   Foster home placement
   Placement in private training schools and institutions
   Operation of temporary detention facilities
   Operation of shelters for long-time care, including some training services
   Casework services to children in their own homes
   Child guidance and psychiatric services

b. In 10 agencies a large share of the funds available for use in this field are expended for children and youths referred by the Courts, though in no case is the service limited to court cases. These are:
   Catholic Boys Guidance Center
   Catholic Charitable Bureaus (three)
   Children's Aid Association
   Everett House
   Florence Crittenton League — Welcome House
   Morgan Memorial — Goodwill Inn and Village
   Orchard Home School
   Citizenship Training Department of the Boston Juvenile Court

c. Some other agencies will accept a limited number of referrals from Courts or parole officers, but in the main both such requests and the acceptances are a minor phase of the agencies' services. The most important such agencies are:
   Avon Home
   Boston Provident Association
   Church Home Society
   Family Society of Greater Boston
   Jewish Family and Children's Service
   Judge Baker Guidance Center
   Massachusetts SPCC
   Somerville Family Society
   Travelers Aid Society

(Note: Still other agencies occasionally provide services to an individual, but acceptances are too few to warrant listing agencies here.)

The above reveals the confusion which exists among almost all child care agencies in relation to protective care. Only a few of these agencies have been principally concerned with protective services.

Basic protective services should be rendered by tax-supported agencies. When this is brought about, voluntary agencies, with the exception noted below, need make no special provision for any protective services they may continue to give. Such services would be given at the request or on referral of the public agency; public responsibility, financial and otherwise, would be established; and the service rendered by voluntary agencies would be in line with their proper field of service, whatever that might be.

The private agency best equipped by tradition and experience to carry on whatever principal protective function remains to voluntary agencies is the Massachusetts Society for the Prevention of Cruelty to Children. In view of this fact—

We Recommend that (1) the MSPCC should continue a program of protective services to children in the Greater Boston Area; such service to include but not extend beyond the fields of neglect, delinquency, and work with the Courts and with other agencies in these areas. This recommendation refers only to such voluntary effort in this field as is properly a supplemental, experimental or specialized service, apart from the recognized responsibilities of tax-supported programs. Many services, such as that of detention care, should be undertaken only on a limited basis and as a temporary expedient. (2) The Society should discontinue such work as properly belongs in a family casework or general child care agency. (3) The Society should devote a substantial part of its effort to its original purpose, namely. the promotion of better community standards and legislation affecting the welfare of children.

The Citizenship Training Department of the Boston Juvenile Court was established in 1936 as an experiment to study and diagnose the problems of boys placed on probation and to make recommendations for their subsequent treatment by the Court and other agencies. It is privately sponsored and financed.

The Citizenship Training Department is recognized as a valuable adjunct to the Boston Juvenile Court and to such other courts as use it. Its intensive study and treatment, coming immediately after a boy's adjudication, make it possible for the boy's problems to be diagnosed, recommendations to be made, and efforts at rehabilitation to be started. Earlier studies made by the Greater Boston Community Council (1938, 1940 and 1946) have pointed out the effectiveness of the work of the Citizenship Training Department, and have recommended that the project be incorporated as a separate agency and inferentially that it be supported by the Community Fund.

The support of the Citizenship Training Department during an initial experimental period was legitimately one which voluntary funds should bear. Because, however, the program is concerned with the rehabilitation of adjudicated delinquents, and because such rehabilitation is recognized as a public responsibility, we think the program should be carried on by a tax-supported agency. Such agency could be the courts, the Board of Probation or, preferably in our opinion, the newly created Youth Service Board. The present special services of the Citizenship Training Department — physical examinations, psychometric testing, guidance and counsel by trained personnel — could be provided by having the public agency employ qualified full-time staff, and part-time consultants and specialists, or such special services could be purchased (at full cost )from private agencies equipped to give them. It does not seem reasonable to maintain indefinitely an independent voluntary agency for the purpose.

But until the Youth Service Board can take over the program of the Citizenship Training Department, we believe voluntary agencies now serving the Greater Boston Area should provide the specialized services needed. Therefore:

We Recommend that as soon as possible, the newly created State agency, the Youth Service Board, should assume and develop the protective and rehabilitation services to delinquents now provided by the Citizenship Training Department of the Boston Juvenile Court; and that until such program is taken over by the Youth Service Board, the cost of operating the program through voluntary agencies should be reimbursed to them from tax funds. The Massachusetts Society for the Prevention of Cruelty to Children and other voluntary agencies should provide such portion of those services as fit their respective programs.

(3) *Group Care Facilities for Study and Treatment*

The New England Home for Little Wanderers is carrying on a diversified, large scale program that serves not only Greater Boston but the balance of Massachusetts and indeed New England. Our recommendations take advantage of what we believe to be its strongest feature, and of course are restricted to its activities in Greater Boston.

We Recommend that (1) the New England Home for Little Wanderers should confine its work in Greater Boston to the provision of diagnostic study and resident treatment of children on a temporary basis; (2) this agency should discontinue its other services in Greater Boston, specifically transferring to the Children's Aid Association its foster care services and establishing close working relations with the Association; (3) the agency should merge and consolidate with Welcome House (Florence Crittenton League), Everett House and Orchard Home School.

There being too little assembled and well understood information regarding institutional services for Greater Boston children:

We Recommend that the Greater Boston Community Council should undertake a study of available facilities for the institutional care of children and the use and need of such facilities. The study should be made by the Research Bureau of the Council, in consultation with the Council's general child care committee recommended above.

(4) *Child Guidance*

See the summary of our special report on child guidance clinics.

(5) *Services Related to Children*

*Adoptions.* The Boston Children's Friend Society is carrying on a standard and eminently worth-while child care program. Its work with adoptions is particularly good. We think it should become the community's primary non-sectarian resource in that field, and to that end:

We Recommend that (1) the Boston Children's Friend Society should devote its full substance to adoption services; (2) its foster boarding care services, together with the foster homes involved, should be transferred to the Children's Aid Association; (3) all of its remaining services should be transferred to other appropriate agencies.

*Unmarried Mothers.* Four voluntary maternity homes and shelters and one public agency now serve unmarried mothers and their babies in Greater Boston. They are —

Florence Crittenton League (Maternity Home and Hospital)
Hastings House
Salvation Army (Evangeline Booth Home)
St. Mary's Infant Asylum and Lying-In Hospital
Tewksbury State Hospital

In addition, a number of other agencies provide services of different kinds for unmarried mothers, — family agencies, children's agencies, medical social work departments, public and voluntary hospitals, the State Division of Child Guardianship, and the Massachusetts SPCC. The picture is a confused one, and the confusion is increased by the fact that, because there is no central reporting service in this field, the total number of unmarried mothers served in a year is not known. To lessen the confusion, and to establish strong leadership and more effective service in the non-sectarian field:

We Recommend that (1) the Greater Boston Community Council provide a central statistical reporting and registration service to cover all agencies dealing with unmarried mothers; (2) the Greater Boston Community Council give early consideration to better coordination and improved standards of service for all such agencies; and (3) prior to 1950 the Maternity Home and Hospital of the Florence Crittenton League of Compassion and Hastings House merge and consolidate, utilizing their existing facilities.

When the recommended merger has taken place. all other agencies giving service to unmarried mothers on a non-sectarian basis should use to the full the stronger agency thus created. A strong consolidated agency in this field will provide more efficient services, and should lessen the pressures on other agencies,not specializing in this field but now forced to provide service because of the present division or lack of adequate facilities. (See our Hospital Division Report.)

*Sectarian*

*Catholic*

Three Catholic agencies provide foster boarding care in the Greater Boston Area — the Catholic Charitable Bureau of Boston, the Catholic Charitable Bureau of Cambridge and the Somerville Catholic Charities Centre. Eight Catholic institutions for children and one maternity shelter in Greater Boston are listed in the 1945 Directory of Catholic Agencies and Institutions. Another institution, the Catholic Boys' Guidance Center, is the Catholic institution for children which participates in central financing under the Greater Boston Community Fund.

There is no doubt that the total resources for Catholic social services in Greater Boston are needed in an amount equal to that now provided. We believe, however, that these resources could be used to still better advantage. To that end:

We Recommend that (1) the three Catholic Charitable Bureaus should be consolidated under one administrative — as they are under one ecclesiastical — direction. The three present offices should be maintained and the areas of service coverage should be redefined. (See similar recommendation in Voluntary Casework Division Report, Family Services). (2) The consolidated Bureau and its operating units should. in this field of child care, serve as Catholic Centers for child welfare services

not otherwise available. These Centers should likewise serve as information, liaison and referral centers for their own constituents, including institutions and agencies. (3) Catholic institutions and specialized agencies should be so intimately associated with the proposed Catholic Charitable Bureau for Greater Boston as to assure full and effective utilization of service and resources within an over-all plan and direction.

In this manner, all Catholic institutions or agencies with the Greater Boston Area of the Archdiocese can find their most effective usefulness and specialization or area of service.

*Episcopalian*

The Church Home Society provides a variety of services to children in connection with its foster care program. In conformity with our basic proposal in the child care field — that whenever practicable agencies should specialize in one major function:

WE RECOMMEND that (1) the Church Home Society should reduce or eliminate its corollary activities and special services (viz., family casework, medical services, adoptions, etc.) not directly related to its primary function of foster care, using other specialized agencies whenever practicable and in keeping with its ecclesiastical policy. (This recommendation is not directed to the work of the Society in interpreting its work to and educating Episcopal lay leadership.) And (2) The close working agreements and relationships between the Society and the Children's Aid Association should be still further developed, especially while our recommendations pertaining to the Children's Aid Association are being carried out. The over-all position of the Association, and a flexible use of its resources by the Church Home Society, would result in more economical and effective operations.

*Jewish*

The Jewish Family and Children's Service is carrying on a varied and excellent service in the family and child care field and have combined family and children's services in a single agency.

WE RECOMMEND that the Jewish Family and Children's Service should continue to operate in its present manner, continuing to give leadership in its field and working closely, through the Greater Boston Community Council, in the future development of child care services in Greater Boston.

## *(c) Day Care Services for Children*

There are many kinds of centers for the day care of young children, but the Survey was concerned primarily with those supported by voluntary funds, including demonstration centers now receiving Community Fund grants.

*Protection of Children in Centers*

Preliminary to consideration of such centers, attention should be directed toward the legal regulation of all centers. Establishment and enforcement of minimum standards for day care of children is a governmental responsibility and should protect all children receiving day care in groups. Adequate protection of children through licensing is possible only when legal provisions require employment by centers of well qualified staff and a constructive educational program as well as satisfactory sanitary conditions, fire protection, building standards and medical supervision.

In Massachusetts, day care centers are licensed by local boards of health. The Boston code is not sufficiently explicit concerning qualifications for day care staff and program, and should be strengthened in these particulars.

*The Function of Day Care Centers*

The function of voluntary day care centers is to provide care for children whose mothers cannot give them the daytime care they need in their own homes and for whom nursery care is the social solution best adapted to the particular situation. The most frequent reasons for the need for care outside of the home are the mother's employment, her illness, the illness of another member of the family, presence in the home of disturbing persons or conditions, and problems in parent-child relationships. Any one of these causes may be more amenable to treatment of a different type, and the center if it is to fulfill its function, must have a qualified person to help the parent select the most effective means of meeting the situation. Nursery education techniques, and therapy adaptable to the nursery setting, should be utilized in giving service to children in the center and their parents, but neither nursery education nor therapy is the basic function of the voluntary day care center.

Over and above such voluntary centers, it should be recognized that nursery school experience has values for all children. The eventual goal of every community should be the extension of the public school system to include half-day nursery schools. Attendance at such schools should not be compulsory, and guidance should be available to assist parents in deciding whether their children are ready for and will benefit from nursery school. Full-day care should also be a goal of the public school system, provided adequate safeguards in the selection of children are established and maintained.

At the present time communities have not generally accepted nursery school experience for all children as a public responsibility. Voluntary centers cannot assume this responsibility for all children, nor can they be expected to solve general social problems, such as bad housing, poor community conditions, and inadequate playgrounds or health services.

*The Voluntary Day Care Centers of Boston*

Of 26 active voluntary day centers known to the Greater Boston Community Council in 1948, 3 were independent agencies and the remainder were associated with settlement houses. Our full Report on Day Care Services (Voluntary Casework Division) discusses in some detail the length of time these centers are open; relations between the center and the parents of children cared for in the centers; intake policies; use of casework service; quality of service rendered in the centers; attendance and policies of enrollment; fees; records maintained in the centers; participation in the work of the centers by members of their Boards; personnel practices; and costs. In summary, it may be said that day care centers of Boston do not have a well developed philosophy based on a certainty as to their function; and their practice in relation to each of the above topics, though often of high standard, is spotty and uneven. These weaknesses point to the need for a structural reorganization of the whole day care establishment in Boston, in order to achieve a higher quality and greater economy of performance by existing centers and to create an organization that can work with single-minded effectiveness toward desirable long term objectives. To this end we propose recommendations aimed toward both short term and long term goals.

*Goals to be realized by 1950*

We Recommend — that the Greater Boston Community Council should bring into being a Day Care Association responsible for organizing and operating day care centers, with an intake policy based on sound casework standards, in the parts of the City where such centers are needed. The nature and duties of this Association are set forth in detail in our full Report on Day Care Services, Voluntary Casework Division. Here it may be said that its plan of operation should include: (1) Receipt of allotments from the Greater Boston Community Fund, based on demonstrable needs and not in excess of present total allotments to other voluntary agencies for the operation of such programs (allotments for this purpose to such other agencies to be discontinued); (2) employment of qualified staff; (3) arrangement with the Boston School Department for the use of space in elementary schools, such space to be without charge to the Association; and (4) arrangement with voluntary agencies, when tax-supported facilities are not available, for the use of their facilities suited to the needs of these programs, without charge to the Association, and the agencies to control these facilities. (See Recommendation 44, Recreation and Group Work Division Report.)

It should be noted that, among other changes, this recommendation would require the gradual relinquishment of day care services by settlement houses and the merging of independent centers with the proposed Association.

*Future Goals*

We Recommend — That the Greater Boston Community Council, the proposed Day Care Association, and all other interested parties work to attain the following future goals: (1) Support from tax funds of full-day day care centers with selective intake based on individual needs and not restricted to the children of working mothers alone; (2) a reduction in the number of voluntary day care centers, and their utilization for explanation of improved techniques, research, training, care of children not accepted by tax-supported centers, and evaluation of group and individual therapy for children and parents; (3) adoption of a licensing code on a state-wide basis requiring all day care centers to be licensed and to meet higher standards; (4) administration of such licensing code by the State Department of Public Health, with the staffs of the State Departments of Public Welfare and Education available for consultation and participation.

## *(d) Child Guidance*

Psychiatric services to sick children in Boston are on a high qualitative level, especially in voluntary child guidance clinics. Like other cities, however, Boston is unable to obtain sufficient qualified staff to meet even a small part of the requests for this kind of service. While there is no doubt that more psychiatric clinics are needed, no steps to increase the amount of clinic service should be taken until existing agencies have made a fuller use of their present facilities and have worked out better integrated relationships and arrangements for sharing common problems with others who provide various specialized services to children. The lack of coordination for all types of service to children was plainly evidenced.

*General Recommendations*

The long waiting lists of children requiring treatment from voluntary clinics emphasize the inability of these clinics to meet requests for service from many other community agencies. To help meet this situation:

We Recommend — that (1) child guidance clinics should provide full information regarding their general and current intake policies to the suggested central child care information and referral center recommended in our Report on Voluntary Child Care Services; (2) agencies referring cases which the child guidance clinics are unable to accept should use the suggested referral center as a first step in effecting alternative care whenever other appropriate social services are indicated; (3) child guidance clinics should periodically screen their waiting lists to determine whether cases they cannot take on now, or are unlikely to see for several months, might not receive an intensive kind of help in another community agency where caseloads are less heavy; (4) child guidance clinics should carefully differentiate their cases, referring all they can to such public agencies as the State Mental Hygiene clinics and retaining those requiring a qualitative service which existing public agencies cannot as yet render; (5) psychiatrically oriented child guidance and child care programs should be initiated or strengthened in such public agencies as the Juvenile Courts, the Public School System, the Division of Child Guardianship, the Metropolitan State Hospital and others; (6) child guidance clinics should make every effort to develop newer techniques of treatment and to carry on research, especially as regards group treatment as a supplement, on the preventive level, to individual treatment; and (7) child guidance clinics should so far as possible extend their training programs, to the end of producing more skilled therapists as rapidly as sound practices permit.

*Specific Recommendations*

To supplement the foregoing general recommendations, and in consonance therewith:

We Recommend that (1) child guidance clinics should not expand in size or number until the steps suggested in the foregoing general recommendations (1), (2), (3), (6), and (7) are well along; (2) a more effective use of the group study and treatment program of the New England Home for Little Wanderers should be made (see our Report on Voluntary Child Care Services; (3) the Morgan Memorial Hayden Goodwill Inn should undergo a major reorganization under psychiatric leadership, and with regard to the confusion of religious and therapeutic goals; (4) the Children's Mission to Children should be merged with the Children's Hospital, and psychiatrists and psychiatric social work staff should be added to the latter; (5) the Habit Clinic should be reorganized so as to provide a better qualified staff capable of performing all aspects of psychiatric treatment for children, greater use as a training center for professional persons, and the appointment of a full time Director; but if, for financial and other reasons such reorganization is impossible, the Habit Clinic should merge and consolidate with the Children's Hospital — on condition, however, that the Habit Clinic's facilities and services are reserved, at least in part, for a continuation of generalized (non-hospital) community services.

## *(e) Apprehension, Disposition, and Treatment of Juvenile Offenders*

Special Note

Field work on this study was nearly completed in 1948 when the law creating a Youth Service Board for the Commonwealth of Massachusetts was passed. Some of the problems apparent at the time of the study, therefore, may have been solved or be in the process of solution when this report is published. The law gives the Board broad powers, so it is obvious that the full impact of its provisions cannot be predicted at this time. Furthermore, the potentials of the new Board must be kept in mind in measuring and appraising any operation touching the field of juvenile delinquency.

Under this law, after January 1, 1949, all juvenile offenders committed for delinquency to the care of the State by any court in the Commonwealth will be committed to the custody and care of a Youth Service Board. The Board of three members appointed by the Governor is a separate division of the Government of the Commonwealth under the Governor

and Council. It has broad powers to study and treat delinquents by the use of any of the existing state training schools (for the management of which the Board becomes responsible), or by the use of private institutions, or by the use of foster homes, or by other suitable means. Adequate psychiatric, psychometric and medical facilities, by which the Board is to determine the individual delinquent's needs for commitment to a school, his placement in a foster home or his return to his own home without commitment are to be developed, and, by July 1, 1949, the Board is required to have established a separate diagnostic clinic for the study of committed delinquents for periods of four to eight weeks before final plans are made for treatment. All committed delinquents become the responsibility of the Board until their majority, or until discharged by the Board. The Board must also develop a crime prevention program.

In addition, the Board is empowered to send consultants into any town or city on request to advise about programs for the prevention of delinquency. Except for this advisory service, the Board does not operate prior to the moment of commitment, and has no jurisdiction over court procedure or juvenile probation.

The work of the Board is to be financed through appropriations by the General Court. It seems certain, therefore, that the Board's success will depend to a large extent on the amount of funds allotted to it. It would seem obvious, also, that these appropriations must be *above* those previously made for the State training schools if the provisions of the law which require development of additional diagnostic facilities and of a crime prevention program are to be carried out. The importance of a crime prevention program is emphasized in this report.

While the law creating the Youth Service Board calls for the development of better facilities for the study and treatment of delinquents, there are, in our opinion, several omissions in its own provisions. First, there is no mention of qualifications for personnel who deal with delinquents, a major issue emphasized in this report. Second, we believe the new law does not provide adequate safeguards against possible miscarriages in the cases of juvenile offenders over whom jurisdiction may be extended after they have reached their majority. Finally, it should be noted that there is no provision for improvement in the quality of diagnostic or treatment services for the large group of children on probation, yet three-quarters of all juvenile delinquents sentenced are on probation or suspended sentences. Therefore, because of the limitation of the authority of the Youth Service Board to those committed by the courts, we fear that there is a chance that the proposed battery of services will be used for only a small proportion of the children who are in need of physical, mental and psychiatric examinations.

In considering the apprehension, disposition and treatment of juvenile offenders, it should be noted at the outset that there is general confusion in the laws of the Commonwealth as to what is a "delinquent" child. Three different chapters of the General Laws of Massachusetts define behavior which makes a child, from seven to seventeen years old, "delinquent", "wayward", "stubborn", a "truant" or a "school offender." The law prescribes specific penalties for each.

*Too Many Official Agencies*

The multiplicity of tax-supported agencies involved in the treatment of juvenile delinquents is one of the greatest barriers to the development of a coherent and effective program. Under the present system, the following major divisions of government bear some responsibility for wayward, delinquent and truant children in this area.

The School Committees and Attendance Officers in Boston and 54 towns and cities in the Metropolitan Area

The Police Departments of Boston and 54 towns and cities

The Boston Juvenile Court and 23 District Courts

The Superior Court which hears appeals from District Court decisions and "bound over" criminal cases involving juvenile offenders

The Probate Court for commitment of mental defectives and the mentally ill

Four County Sheriffs in charge of jails where some delinquents are held

County Commissioners of Middlesex through its County Training School

City and Town Departments of Welfare required to pay costs of temporary detention prior to adjudication

The State Department of Public Welfare which operates Tewksbury Hospital and the Division of Child Guardianship

The State Department of Correction through its reformatories

The State Board of Probation

The State Board of Parole.

The State Department of Mental Health through its schools for the feebleminded, mental hospitals and clinics

The Youth Service Board.

Contrary to popular belief, the Boston Juvenile Court hears only cases within a limited geographical area of Municipal Boston (the North, South and West Ends, and Back Bay). It differs from other courts in that it hears no adult cases in which the major issue is not the welfare of a child. In 1945, 1946 and 1947, for instance, the Boston Juvenile Court heard less than 30 percent of all juvenile offenses brought before the courts of this city.

Twenty-three Municipal and District Courts, each with widely divergent standards of personnel, procedure and philosophy, are concerned with juvenile offenses. These courts spend only a small part of their time hearing juvenile cases and vary also in the number of sessions held per week. The Roxbury District Court holds only two juvenile sessions a week and 6 courts in Boston and 16 in other districts hold only one session a week, as compared with the Boston Juvenile Court, which holds six sessions a week.

There is no state-prescribed code for the intelligent, safe and effective treatment of juvenile offenders and the protection of their constitutional rights.

*Lack of Adequate Records*

Sound planning of any program of social services requires knowledge of the number of people to be served. At present, two offices collect information on court cases, but a different set of facts is required by each. Courts use different methods in reporting to the Department of Correction, and in one instance the same court varied its method year by year. School attendance officers, with few exceptions, fail to state the number of children involved in truancy cases, and the Boston Police Department does not report the number of children arrested for specified offenses.

Standards of record-keeping are of the utmost importance in understanding and evaluating the problem of delinquency and should be established and maintained by qualified personnel.

*Lack of Qualified Personnel*

There is generally a lack of qualified personnel in state and local agencies dealing with juvenile offenders. Minimum educational and experience requirements for admission to civil service and other examinations in this field should be evolved by competent specialists.

With a few notable exceptions, staff members of tax-supported agencies in Massachusetts who work directly with children in difficulty are not qualified to give maximum help to these young people, or to protect the public against destructive acts resulting from delinquency. No special requirements are found for police officers assigned to juvenile work; District Court judges are appointed without special regard to skill in treatment of juvenile delinquents; there is no competitive examination for testing a probation officer's knowledge and skill in treating problem children. Some officers have college degrees and social work background and experience. The education of others did not progress beyond grammar school. Clerks of Court, who have wide powers of discretion, often are not qualified to act on complaints. The same lack of trained personnel is found in the training schools and attendance departments of the public schools.

Some positions are under Civil Service, but this is no guarantee of high qualifications. The Veterans Preference Laws prohibit the Civil Service Commission from setting effective educational requirements.

*Need for Special Temporary Detention Facilities*

There are no tax-supported special temporary detention facilities for arrested juvenile offenders in the Greater Boston area.

A child brought before the court may legally be detained (a) when he is arrested; (b) at preliminary hearing before an investigation has been made; (c) during continuance of his case; and (d) after his case has been judged. Juvenile offenders are detained in county or city infirmaries, homes for the aged or ill, House of Detention for Women, city jails or police stations. A few can be cared for in homes operated by voluntary agencies, but the number is extremely small.

At the present time it is possible for an arrested child, if he is unable to obtain bail, to spend anywhere from one to 60 days in jail before he has been convicted of an offense. One 15-year old boy, charged with the theft of a car, was held in jail for 59 days. His case was continued three times.

Some easing of the situation may be expected under the 1948 law which requires commitment of all children between seven and fifteen to the Youth Service Board or to a probation officer, if for any reason their cases are pending after hearing. Judges also may commit children from 14 to 17 to the Board if the only other alternative is jail.

The Youth Service Board has under its control three State Training Schools — Industrial School for Girls at Lancaster, Industrial School for Boys at Shirley, and Lyman School for Boys at Westborough. These schools, however, are primarily for long term commitments, and there is a question as to whether there would be room for short-term detention, or whether the program would be suitable, even if the Legislature should provide funds for the purpose. The Board is also authorized to set up foster homes for children under its care, but it should be noted that children held prior to hearing in court are not included in this plan.

*The Attitude of the Judge*

The number of juvenile offenders committed to institutions is low in all the courts of Boston, but court decisions vary to an extent which seems to indicate that the judge's attitude is the determining factor.

Juvenile commitments in Boston are low compared to cases put on probation, and in the three-year period studied they dropped from 373 in 1945 to 175 in 1947. Only 1.7 percent of the juvenile offenders in the Boston Juvenile Court were sentenced to institutions, compared to a high of 11 percent in the First Eastern Middlesex Court. The same institutions are used by all courts. The only factor, therefore, which accounts for this spread seems to be the judge's attitude.

In the three year period from 1945-47, 809 juvenile delinquents were committed to an institution: 626 to State Training Schools; 127 to county schools for truants and school offenders; 19 to the Massachusetts Reformatory; and 37 to other institutions.

Commitment of truants and school offenders to county training schools may still be made by juvenile court judges, or such offenders may be committed to the Youth Service Board. This means that if a judge so decides, truancy, now almost universally recognized as a symptom of graver difficulties, may still be treated as a separate entity and boys brought in to court on that charge may be deprived of the diagnostic and treatment facilities to be provided for other kinds of offenders. County training schools exist as separate units, not a part of the State's system for juvenile offenders.

At the present time, of two boys convicted of truancy in different courts, one may be committed to the Youth Service Board where the chances are good he will be released on parole in a matter of months. The other may be sent to a county training school where the chances are he will remain for a long period and may be held until his 16th birthday. Conversely, of two wayward or delinquent boys who have committed identical offenses in different areas, one may be sentenced as a truant to be released from all control at 16, while the other may be committed on a graver complaint of delinquency or waywardness, with the possibility he will be kept under supervision until he is 21 or 23 years of age.

There is nothing in the present judicial system in Massachusetts to suggest that this difference in treatment is based on a careful and scientific study of the individual boy or girl.

*Appointment of Probation Officers*

In the field of probation, there is no centralized agency with appointing, evaluating and dismissing powers over probation officers. The power of appointment of probation officers lies with individual judges.

Various efforts have been made to remedy the out-dated practice of such personal appointment of public servants. Some advance has been registered in the setting up of standards for probation officers. For example, judges are now required to state names and qualifications of all proposed appointees to the Administrative Committee of the District Courts, which in turn submits the list to the Board of Probation. But power of *appointment* remains with the judges. Under present conditions the Board of Probation is, in fact, in the anomalous position of being apparently responsible for the quality of probation work in the State without the authority which would make its decisions and thinking effective. Appointments of qualified personnel are of the utmost importance in probation service. Figures reveal that between 75 and 80 percent of sentenced cases are placed on probation, and in Massachusetts probation officers are allowed to assume unofficial responsibility for deciding whether a juvenile offender on probation shall be held pending his trial or be allowed to return home. It was encouraging to find, however, that new appointments have tended to be on a much higher level than formerly.

At the present time the distribution of juvenile probation officers bears no relation to the distribution of juvenile population, or of charges brought against individual young people in the respective courts, or of appearances before such courts.

*Differences in Disposition*

An analysis of dispositions of all juvenile cases for the last three years shows wide variation in the practice of the different courts. It appears that this variation stems from ambiguity in the laws, and from differences in the personality and the approach of judges and in their interpretation of the law. The figures reveal the lack of a consistent and comprehensive system of judicial procedure.

The number of cases dismissed, discharged and nol-prossed was high in 1945, 1946 and 1947. From 23.4 percent of all cases in 1945, it increased to 29.6 percent of all cases in 1947. This might mean that there were insufficient grounds for complaints in many cases; or that there was inadequate presentation of evidence; or that, in spite of the practice of entering each act complained of as a separate charge, some judges tried only one charge against a child and disposed of additional charges by one of the three methods named above.

Cases placed on file decreased from 29.7 percent of all cases in 1945 to 18.5 percent of all cases in 1947. "Placed on File" records may have serious effects on a delinquent because his case as a result remains unsettled. But the decision could mean a growing concentration by the judges on individuals, as contrasted with offenses. A filed charge may be reopened if the child reappears on another charge.

Dismissed and filed cases accounted for nearly one-half of all cases against juvenile offenders in the three years.

Of all those sentenced in 1947, 80.9 percent were placed on probation compared to 75.7 percent in 1945. The numbers as well as the percentages highlight the tremendous importance of the number, quality and training of probation officers, especially when their responsibility for investigations is also considered.

There were only 114 appeals of juvenile cases reported to the Board of Probation in 1946 from all courts of the Commonwealth. Sixty-three were from the seven Boston courts. Appeals cost more than most families can pay and the juvenile offender may remain in jail if bail is not posted.

*Importance of Crime Prevention*

Although progress has been made, the Boston Police Department has not as yet achieved a satisfactory unit to prevent crime by young people. The Boston Police Department handles juvenile delinquents in three ways: through officers on the "beat"; through special officers assigned to divisions; and through the Crime Prevention Bureau. The staff of the Bureau consists only of women officers, a male captain, a male lieutenant and a woman sergeant, although the Rules and Regulations of the Police Department state there shall be male as well as female officers in the Bureau.

It should be emphasized that, *within limits*, an excellent job has been done by the staff of the Crime Prevention Bureau, but their work cannot be said to be *preventive*, a fact substantiated by the record in 1946, which shows 2,956 arrests of juvenile offenders, 206 credited to the Bureau.

The cases with which the Bureau is chiefly concerned are those observed by women officers as they patrol certain limited areas and inspect dance halls, cafes, theatres and transportation terminals. Its work deals largely with very young children and girls, who are, generally, runaways or sex delinquents.

There appear to be no instructions for the detection and prosecution of adults contributing to the delinquency of minors. These adults train young people to "break and enter"; act as "fences" in disposing of stolen goods; sell guns and drugs to young people; exploit them sexually; and are the beneficiaries of a great variety of unlawful acts committed by young people.

Superior officers in the Police Department should be charged with studying juvenile delinquency in the city and with training officers in special police work with juveniles. There is great need for developing an effective program for the prevention of crime and for strengthening police service to young people generally.

*Need for a Coordinating and Directing Center*

There is great need for a coordinating and directing center for all work of the Police with juvenile delinquents. A city the size of Boston, where young people are charged with nearly 3,000 offenses per year, needs a coordinating and directing center for all police work with juvenile delinquents. The center should also be specifically responsible for a strong, effective crime prevention unit under centralized direction, whose duties it would be to detect adults who are instigators of felonious acts by minors; to clean up and take appropriate action against places of public entertainment which exploit young people; and to establish a code of conduct for officers called on to arrest a youthful offender.

It has been noted that the new Youth Service Board has been charged with the duty of developing a preventive program. Obviously this depends on funds provided by legislative action. If funds are limited to cover only reorganization of the institutions under its charge, then an effective preventive program will not be carried on. An awareness of the importance of prevention on the part of the public, of voluntary social agencies, and of public officials in particular, is essential.

*Difficult School Children*

Greater attention and direction should be given to difficult school children, especially in the larger school systems.

A report of the Committee on Education of the Boston Schoolmen's Economic Association (April, 1946), entitled "Discipline in the Boston Schools," advocates extension of the Disciplinary Day School method, now discontinued in nearly all large cities, and more homework as a disciplinary measure. Such a recommendation overlooks educators who have studied the problem of discipline; the fact that increased

homework to children already in trouble brings on more failure; and the fact that today's overcrowded homes present few opportunities for even the most studious child to find necessary quiet. (A study of maps on population and crowded areas used in other parts of this Survey shows a positive correlation between housing, economic conditions and juvenile delinquency).

Truancy is usually one of the first pieces of evidence of a child's break with community standards. At present, attendance officers are authorized to serve warrants, make arrests, and appear as witness against a child and or his parents. They also serve as parole officers when a boy is released from a county training school (if his offense is a school offense), and as probation officers for school offenders brought into court. They are appointed directly by the School Committee from Civil Service lists. There is preference for veterans and special preference for disabled veterans. There are no educational requirements for these positions, and yet initial treatment of truancy cases has been left with attendance officers.

The so-called Strayer Report (Boston School Survey), conducted under the auspices of the Finance Commission of the City of Boston in 1944, points out the need for trained attendance officers able to discover the reasons for truancy. It urges coordination of their work with the Division of Juvenile Adjustment and other divisions of the Bureau of Child Accounting. The Cambridge School Survey (1947) recommends the gradual elimination of four of the five positions of supervisors of attendance on their retirement and the establishment of three social worker positions under the Director of Guidance and Related Services. Both reports recommend strengthening various divisions of Child Guidance, Vocational Counseling and similar services.

The Rules of the School Committee require clearance by attendance officers with the Division of Juvenile Adjustment — but not its approval — before a child is taken into court as a truant or school offender. However, in the important step of transfer of children to the Godvin Disciplinary Day School, no requirement is made for clearance, service or approval. The majority of the 1,028 children referred to the Division in 1947 were neither court cases nor disciplinary cases, but were referred by classroom teachers, not by attendance officers. The median age of those referred was over 13 years, a fact which shows that problem children in Boston Schools are not being given early diagnostic treatment.

It should be emphasized that neither the Boston nor the Cambridge School System has an effective census of school age children taken annually and used regularly as a check on attendance. Children of school age can be in the community without attending school. Active files and an annual census are as much a responsibility of school authorities as is the quality of education.

*Recommendations*

The laws affecting school offenders, truants, and wayward, delinquent, and stubborn children, are not only enormously confusing, but by their permissive phrases and contradictory character may be used to deprive a child of his basic rights. A clear and comprehensive codification of all laws relating to the apprehension, disposition and treatment of all types of juvenile offenders is needed. Therefore —

We Recommend — That a complete rewriting should be made of all pertinent chapters and sections of chapters in the General Laws of the Commonwealth which define and prescribe penalties for school offenders, truants, and wayward, delinquent or stubborn children so that they will be stated in clear, comprehensive and understandable language. Definition of acts and procedures for the apprehension, disposition and treatment of all types of juvenile offenders should be given, with recognition of the principle that indeterminate sentences and permissive clauses and phrases must be accompanied by adequate safeguards of the constitutional rights of the offender.

Because it is important to have the fate of children in trouble with the law determined by trained, qualified officials, and to have their legal rights carefully safeguarded —

We Recommend — That there should be passed a Children's Court Act establishing separate courts with specially qualified judges and probation staffs for the hearing of all cases involving children, and clearly defining and limiting the powers of probation officers and clerks of court with regard to unofficial disposition of juvenile offenders. Such an act would preserve and extend the scope of the Boston Juvenile Court and would replace pertinent chapters of the General Laws which give jurisdiction in district and municipal courts over cases of neglected children or juvenile offenders. In the first instance, such legislation should be applicable only to the Greater Boston Area.

Because full and accurate records are indispensable to the orderly disposition and treatment of juvenile offenders —

We Recommend — That there should be centralized in one State Department responsibility for the gathering and compilation of statistics on juvenile offenders. The system should be based on the number of children involved, and should show the offenses with which they have been charged, the

disposition by police, probation officer or court, the number confined in institutions, on probation and on parole. There should be annual publication of essential data for the information of the public.

The lack of appropriate tax-supported detention facilities for juvenile offenders in the period between apprehension and court appearance has serious consequences. Many such offenders are returned to environments conducive to further delinquencies. Probation officers are forced to expediencies not in the best interests of the children and voluntary agencies to use funds needed for other purposes in order to provide protection for a limited number. Therefore —

We Recommend — That responsibility for the development of temporary detention facilities should rest on the Youth Service Board, with a special appropriation for this service to ensure rapid development of facilities appropriate for the various age groups and in terms of the number of children arrested in the respective communities.

The success of any system for the treatment of juvenile offenders is largely determined by the quality of the personnel in direct contact with the children involved. The employment of unqualified persons in any of the categories, from the highest to the least important, is expensive and harmful. Therefore —

We Recommend — That legislation should be passed which would establish sound standards of training and experience for all positions in State or local service where the incumbents are in direct contact with juvenile offenders; specifically such positions as school attendance officers, police officers assigned to juvenile duty, probation officers, clerks of juvenile courts, parole officers, and personnel in institutions. Future appointments to such positions should be made only after the applicants have passed appropriate examinations prepared by qualified experts.

In order to bring about the changes in law and the increased appropriations needed for a comprehensive system for the treatment of juvenile offenders, the present limited number of informed and interested citizens needs to be greatly increased. The task of developing such an influential body exceeds both the responsibility and resources of voluntary social agencies working in this field, though obviously such agencies should be active participants and provide factual material and leadership. Therefore —

We Recommend — That the Greater Boston Community Council should work with such organizations and groups as the Youth Service Board and its Advisory Committee, the Bar Associations, Leagues of Women Voters, the Association of Women Lawyers, Taxpayers' Associations, civic clubs, religious groups, voluntary social agencies, and others in order to inform the public concerning conditions affecting juvenile offenders, and to organize public opinion in support of soundly devised proposals for change in laws and procedures of both state and local governmental departments.

Because juvenile offenders, like all other offenders, are entitled to full protection before the law —

We Recommend — That pending the development of a comprehensive Children's Court system and a codification of the laws, as recommended above, the Boston Legal Aid Society should request the various bar and lawyers associations to join in working out a practicable method of providing counsel at the Juvenile Courts, available to juvenile offenders and their families, to clarify their rights and protect their interests, and as a means of gathering at first hand evidence of the need for specific changes in the law.

### 3. *Vocational Counseling and Placement*

Modern scientific vocational counseling and placement services are relatively new. They are growing in use and in usefulness with our growing command of the psychological and other sciences on which they are based. In Greater Boston, these services are now carried on for the most part as special services of agencies founded for some other primary purpose, and are adjuncts to the principal purposes of such agencies — e.g., YMCAs and YWCAs, School Departments, family agencies, settlement and neighborhood houses, etc. The State Employment Service and the Jewish Vocational Service are two examples, one tax-supported and one voluntary, of agencies having vocational guidance and placement as their principal purpose. Especially because the field is new and growing, much thought needs to be given to the best relationship of vocational guidance to the entire agency structure and to the community as a whole. If a sound relationship can be established now, future development of guidance and placement services will be far more productive. To aid in achieving this end in Greater Boston, the following findings and recommendations are offered.

At present, vocational counseling and placement services in Greater Boston are being offered almost exclusively to persons within Municipal Boston. Because clients seem to desire facilities closer to their residences than can now be usually found, these services should be more widely distributed.

There is question whether some of the vocational guidance and counseling activities of voluntary agencies should be carried on in their present affiliations. Few of these activities appear to be attached

to agencies because they are germane to the agencies' primary function, or because such affiliation is designed to develop the most effective counseling and placement services.

Most of the agencies visited were carrying on only a part of the complete counseling job of testing, vocational guidance, personal adjustment counseling, and placement. Moreover, we found little clear cut knowledge or understanding of the services which various agencies in the community have to offer; no planned method of referral for supplementary services so as to effect maximum use of community resources; and no formal, systematic coordination between the several voluntary agencies engaged in vocational counseling and placement.

There is need for more vocational guidance in the public and parochial schools of Greater Boston. Part of the burden now resting on voluntary agencies could be eased by further development of the counseling program in the schools. The State Employment Service is also limited in its vocational guidance program; it is important that this agency broaden the scope of its present services and become a primary resource for guidance and placement. Elsewhere state employment services have taken increasing responsibility for a qualitative service with skilled professional staff.

Among voluntary agencies, there appears to be widespread dissatisfaction with the work being done by public agencies. Concern over lack of interested cooperation from public agencies in regard to certain categories of workers, was given by several voluntary agencies as a reason for their feeling that it was necessary for them to keep in operation their own placement activities. On the other hand, little use appears to be made by voluntary agencies of the occupational and educational information available through public agencies. The State Employment Service has a wealth of material, particularly of the job-information type, which could well be used by counselors in voluntary agencies.

There is no uniformity in fee-charging. We endorse uniformity of policy in fee-charging, but we do not believe that individuals or voluntary agencies should pay for a service which a tax-supported agency should and can give.

We noted several areas where the kind of service being given should be developed:

1. Little is being done to organize group guidance programs. This method has been quite successful where it has been applied in other communities, and, if developed here, would make possible more effective use of existing personnel.
2. Little formal effort is being made to organize programs for the guidance of older workers.
3. Little follow-up by any agency appears to be done, once its own service is completed, and no formal method has been worked out to check on cases which might have been previously handled by other agencies. Lack of continuity in work with individual clients is a serious deficiency.
4. Little emphasis appears to be placed either on personal adjustment counseling or on referral for such purpose. Far more consideration should be given to the fact that a person having a problem regarding his selection of a vocation may also have difficulty in his personal adjustment, of which the vocational problem is merely one facet.

The personnel now engaged in vocational counseling appear for the most part to be well qualified for the portion of the work they are doing. On the other hand, social workers are also engaged in vocational counseling, for which they are not trained. Cases requiring specific vocational services should be referred to appropriate agencies.

The salaries of professional workers in vocational counseling positions are low. This point is particularly pertinent becauses several agencies said they were on the verge of either seriously curtailing their vocational counseling services or doing away with them entirely because they cannot recruit adequate personnel at the salaries they are able to offer, or are losing skilled personnel who are leaving for better paying jobs.

We Recommend — (1) To the end that the vocational counseling and placement services in Greater Boston may be more effectively coordinated, the Greater Boston Community Council should set up a section fully representative of all voluntary and tax-supported agencies carrying on counseling and placement services, especially the State Employment Service, the public and parochial school systems, business management, and organized labor.

(2) (a) The State Employment Service and the public and parochial school systems in Greater Boston should expand their programs of vocational counseling.

(b) Tax-supported agencies should provide the bulk of vocational counseling and placement services for the Greater Boston Area; and voluntary agencies should cease to handle cases which tax-supported agencies can handle, referring such cases.

(c) Voluntary agencies should engage chiefly in such specialized vocational counseling and placement services as tax-supported agencies are not able to undertake (e.g., special and highly

technical test procedures; counseling with persons of border-line intelligence; intensive service to emotionally maladjusted or physically handicapped; and otherwise where the time and resources of tax-supported agencies would not warrant providing for specialized needs).

(3) In order to provide a well rounded vocational counseling and placement service for the Greater Boston Area, a Central Vocational Counseling and Placement Agency should be organized promptly as a Community Fund agency (with appropriate financial support, which should be considerably less than the aggregate now provided for the work in this field now being done by numerous agencies). Such Central Agency should:

*(a) Be established by joint action of the Boston YMCA, the Boston YWCA, the Jewish Vocational Service, and the Family Society of Greater Boston;

*(b) Be organized around the staff and skills of those four agencies and such additional skills as may be available, in required technical and professional personnel, from other agencies whose activities in this field are recommended for discontinuance;

(c) Absorb, in so far as required, the services now rendered by each of these agencies in this field; such agencies discontinuing further work in this field;

(d) In so far as the voluntary agency field is concerned, render for Boston *all* the services of interviewing, testing and, in so far as necessary, placement and follow-up.

(4) All small operating units, whose limited skills and resources in vocational guidance do not permit them to render effective service, should discontinue their service in this field promptly. The professional personnel and other resources of such agencies should be released, in so far as required, to the Central Vocational Counseling and Placement Agency.

(5) (a) In the Metropolitan Area, if service is not available through local tax-supported agencies, applications for vocational counseling and placement should be screened through the Social Service Centers or through the Central Counseling and Placement Agency.

(b) The Social Service Centers should not only serve as direct referral sources for vocational counseling and placement, but should provide, either initially or in conjunction with such counseling and placement services, the casework counseling so frequently needed.

(6) Counseling and placement activities should give increased attention to older persons.

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**The Executive Committee of the Survey dissents in part from these Recommendations, for the following reasons —*

*"1. The Executive Committee favors the substance of Recommendation 3—i.e., the proposed creation of a Central Vocational Counseling and Placement Agency.*

*"2. Recognizing the contribution to this field of the Women's Educational and Industrial Union, the Executive Committee believes that the Union should participate in the joint action referred to in Recommendation 3(a) and that its staff and skills should be included with those of the other agencies mentioned in the organization referred to in Recommendation 3(b)."*

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## 4. *Services for the Aged and Aging*

In Greater Boston, as in the rest of the United States, both the number and the proportion of older people are increasing. The trend is toward a population in which there will be a greater proportion of aging and aged persons than of children and young people. The 1940 U. S. Census showed the percentage of people 65 years of age and over to be higher in Greater Boston than in other large urban areas, and to be increasing.

*Public Assistance for the Aged*

Public assistance provisions for the aged in Boston are often inadequate. A major reason for this inadequacy is that a large percentage of older persons now in receipt of General Relief allowances could and should be qualified for Old Age Assistance. Present restrictive State legislation, by narrow "settlement" provisions and denial of Old Age Assistance to all persons not possessing citizenship, prevents such qualification. As the Boston public welfare department grants a weekly allowance of only $12.00 or less, regardless of need, to a person on General Relief, the result is that many elderly persons receive far from adequate public assistance.

Because of this inadequacy of public assistance to the aged, voluntary agencies are often faced with cases where they feel forced to supplement public assistance grants, though their policy is not to do so. Thus we find not only the diversion and misdirection of voluntary funds, but a costly process of inter-

minable conference and maneuvering, on the part of public officials, social workers and other citizens, in order to find ways and means to supplement public assistance grants to meet even the minimum of human and economic need.

*Housing*

The problem of housing is a serious one for the aged. It is true that Massachusetts law allows older people to keep their own property and their equity in it up to $3,000, and there is some allowance for upkeep of property. Therefore, the problem of housing in some of the Metropolitan towns is not as serious as it is in cities, where residential property is seldom owned by the inhabitant or cannot be maintained because of limitations on allowable costs. General Relief recipients, however, are not permitted to retain such property, and at the time of our study no allowance had been made for increases in rents. Even such living quarters as elderly people can get are often both hazardous and seriously unsuitable for the condition and need of these people. Reasonable and humane provisions for this group of disadvantaged persons would cost more; but a considerable offset to such additional costs would be the saving of unnecessary and hidden costs inevitable under present conditions; — for example, prolonged and unnecessary hospital and convalescent care, institutional care, separate maintenance and rental allowances because of forced removal from their own homes or the homes of their relatives, etc.

*Homes for the Aged*

There are vacancies in many homes for the aged in Greater Boston, but applicants are often not eligible because of outmoded intake policies. For example, most of the 44 homes for the aged known to be operating in Greater Boston still operate on a contract or lump sum basis. Some require citizenship and a ten year residence in Boston on the part of all persons they accept. Very few use the Social Service Index, perhaps fearing that a close association with other agencies would threaten the independence of their admissions committees. Records in the Family Society, the Boston Provident Association and the Catholic Charitable Bureau reveal the presence of several boarding homes for elderly women which are of such high standards that the majority of homes could well imitate them.

At present there is no central place in Boston at which a record of vacancies in homes for the aged is kept. For this reason there is constant and unnecessary shopping around on the part of those desiring to locate living quarters.

*Medical Care*

In general, medical care for the physically ill aged seems to be good. There is an excellent geriatric clinic at the Peter Bent Brigham Hospital, and most homes for the aged are properly concerned with the medical care of their clients, many homes having a fourth-year medical student in residence. Recipients of Old Age Assistance receive more and better medical care than recipients of General Relief. In 1948, legislation was passed which should do a great deal to raise the standards of convalescent nursing and boarding homes for the aged.

There is, however, a lack of appropriate facilities for the care of chronically ill and infirm older people. The nearly universal testimony of workers called on to find such facilities attests this lack. As a result, many old people remain in hospitals at a high daily cost when, if places could be found, they might be cared for elsewhere more suitably and less expensively. Unnecessary and costly readmissions of older people to hospitals could be prevented in the same way.

A home medical-care plan or extension of hospital care, which would include medical and nursing services in the home, is needed. Under such a plan, a patient could be transferred from a bed in a hospital to a bed in his own home and still remain under hospital care. In this way, much needed hospital beds and facilities for the acutely ill would be freed.

*Rehabilitation Services*

Old and seemingly helpless invalids can often be enabled to take at least partial care of themselves. Such limited rehabilitation of many elderly patients will do much to assist them in regaining some independence and personal dignity. Any sound rehabilitation program in Greater Boston should make a special point of including service to older people.

*Care of the Senile Aged*

Many senile but not insane older persons are unsuitably placed in nursing homes or in public institutions, or remain at large and are a nuisance to themselves, their families and others. The number of senile

cases is increasing and will continue to increase as more persons live to a greater age. Some kind of interim care, at a cost within the reach of public agencies and of some of the aged persons themselves or their families, is needed to fill the gap which exists in both public and voluntary facilities.

*Recreation for the Aged*

Opportunities for recreation for older people are limited. This is particularly true in homes for the aged. Some Settlements are pioneering in providing special recreation programs for the aged. Any central committee interested in group work and recreation should plan for the recreational needs of older people. (See Recreation and Group Work Division Report.)

*Tewksbury and Long Island Hospitals*

Tewksbury and Long Island Hospitals (both tax-supported) leave much to be desired in the way of buildings, equipment and specialized personnel. This accords with the findings of a study made in 1945 for the Massachusetts Department of Public Welfare. In both institutions, however, we found that patients, and especially women patients, were receiving understanding, individualized care, better care than is known to be given in some proprietary nursing homes. Our full Report on Services for the Aged and the Aging supplies many details for both the weaknesses and the good points of these important institutions.

*A Central Planning Body Specializing in the Aged*

The present Committee on the Aged of the Greater Boston Community Council would be more effective as a Section of the Family and Child Care Division, with representation, both lay and professional, from all groups that are working with or for older people. The community at large should also be represented, and the Section should have the service of competent staff, experienced in community organization.

*Recommendations*

Services for the aged in Greater Boston are badly coordinated. There are several reasons for this. Agencies in many functional fields (family, health, rehabilitation, recreation, employment and others) have a share in work for the aged, and the task of relating and focusing them is a difficult one. A large proportion of the voluntary agencies concerned with older people are homes or institutions for the aged, which have a tradition of independence that makes it hard for them to join in community planning activities. Only 15 survey questionnaires were returned out of a total of 44 that were sent to such homes. There is a relatively small body of centrally collected facts and figures on which planning can be based. In this field, therefore, if substantial improvement is to be made, it is necessary to start much further back in the process of community organization than is true in any other field.

To establish conditions under which such improvement can be brought about—

We Recommend — That there should be established in the Family and Child Care Division of the Greater Boston Community Council a Section on Care of the Aged.

The purpose of this Section would be to bring together lay and professional representatives of all agencies directly concerned with problems of the aged; to promote good standards of work and cooperation with health, housing, recreation, employment and other agencies whose services are available to the aged; to bring about revisions in the admission policies of homes and institutions for the aged, especially those now operating below capacity; to initiate and promote new legislation for, and sound administration of, tax-supported programs for the aged; to give immediate attention to a comprehensive inventory of agencies and services, trusts, funds and other resources designated for the aged.

We Further Recommend — That a Bureau for the Aged should be established in the proposed Federation for family service in Greater Boston. (See Voluntary Casework Division Report, Family Casework Services.)

The Family Society of Greater Boston and the Boston Provident Association now maintain special services for the aged. A consolidation of staff and resources into a new bureau to serve the aged and the aging in Greater Boston should serve as a resource and information center on the needs, problems and services of and for the aged; maintain an inventory of facilities for the aged; and keep a currently active file of vacancies available. The Bureau should be actively represented in the proposed Section on Care of the Aged in the Greater Boston Community Council.

It should give attention to seeing that care is provided for the aged, especially the chronically ill aged, through cooperative programs with hospitals, nursing, homemaker and other services, and through a home medical-care program.

We Further Recommend — That a uniform system for reporting statistics on persons served in all voluntary homes and institutions for the aged in the Greater Boston Area should be established under the direction of the Research Bureau of the Greater Boston Community Council.

The establishment of a uniform method for reporting current statistics on the capacity of homes and institutions for the aged and the number of persons being served in the area is essential for sound planning in this as in other fields of health and welfare services. Sufficient help should be made available in homes for the aged so that good records can be maintained.

We Further Recommend — That the proposed new Section on Care of the Aged in the Family and Child Care Section of the Greater Boston Community Council should give immediate consideration to the development and improvement of services to the aged by voluntary and tax-supported agencies, and to the extension of homemaker service for the aged.

The development and improvement of services adapted especially to the needs and problems of the aging and aged will mean greater security, better adjustment and well-being for the increasing number of older persons in our population. Expansion of the present limited homemaker service now available to the aged should result in financial savings, and will bring happiness to many older persons by allowing them to remain in their own homes.

Consideration should be given to widening the application of the State law governing eligibility for Old Age Assistance by eliminating the present citizenship and "settlement" requirements.

### 5. *Homemaker Service*

Homemaker Service is a service under which competent women, selected and supervised by social agencies, are placed in a home to manage the household. This service may be rendered either without charge to the family or person served, or for such payment as the recipient of the service can make. Homemaker Service was originally developed for use in families with children where the absence of the mother, by death or otherwise, threatened disruption of the family life. Its advantages in such a situation are obvious. Recently it has been seen to have specialized uses, notably in the care of the aged, the chronically ill and the blind. It is still most frequently used in families with children.

In Greater Boston, Homemaker Service is operated only by the Boston Provident Association, which makes the service available to other agencies, both voluntary and tax-supported, and to individual applicants. Policies governing conditions of service, reimbursement and coverage for the Metropolitan Area have been carefully worked out through the Greater Boston Community Council. In our Voluntary Casework Division Report (Homemaker Service), we treat fully the advantages of this Service, the skill with which it has been developed, its popularity with agencies and also with individual families that apply for it directly, the sources of requests for Homemaker Service, and questions of cost.

As operated by the Boston Provident Association, Homemaker Service is of high quality and undoubted value. To increase even its present usefulness —

We Recommend That Homemaker Service be continued as a department of the Federation for family services of Greater Boston proposed elsewhere in our Reports; that no other agency undertake the establishment of a Homemaker Service in Greater Boston; that beginning immediately Homemaker Service be more fully used by family and children's agencies, especially the latter, and that programs of Homemaker Service for the aged, the chronically ill and the convalescent be developed as feasible; that charges for Homemaker Service be made for the present to all Fund agencies on the same basis, but that, when suitable arrangements for extending it throughout the Metropolitan Area have been completed, (1) Fund agencies should not contribute to the cost of Homemaker Service used by their clients, (2) full cost of Homemaker Service used by clients of non-Fund voluntary and tax-supported agencies be charged to such agencies, and (3) in every case where possible clients should contribute to the cost of Homemaker Service used by them; and that the position of Director of the Homemaker Service be reclassified in accordance with accepted standards, the present Director receiving the recognition which such reclassification implies.

### 6. *Rehabilitation Services to the Handicapped*

The record of the City of Boston and the Commonwealth of Massachusetts in services to the handicapped is a long and distinguished one. Such services in Greater Boston, both in scope and quality, compare favorably with, and in some respects surpass, similar services in cities of comparable size. There are some fields, however, in which quality should be improved and scope extended if the handicapped of the Area are to be restored to "the fullest physical, mental, social, vocational and economic usefulness

of which they are capable." The present deficiencies in specific services now available and the lack of sufficient services in specific areas bring out the following findings and recommendations.

*Involving an Increase of Rehabilitation Services Chiefly under Tax-Supported Agencies.*

Boston City Hospital is the key public institution in the medical care of many of the eligible residents of the City of Greater Boston. At present the Hospital's rehabilitation services are limited largely to definitive physical therapy for in- and out-patients. There is no physician trained in physical medicine assigned to this service; the physical therapy staff is insufficient to meet the needs of a 1621 bed general hospital; there is no occupational therapy program. It cannot be anticipated that voluntary agencies in Boston will be able to meet adequately all or even a substantial percentage of the balance of the rehabilitation needs of the community. Therefore —

We Recommend that (1) a strong department of physical medicine and rehabilitation should be established at Boston City Hospital; and (2) such departments should be coordinated with one of the medical schools for under-graduate and post-graduate training, and with one or more of the universities for the training of psychologists, social workers, vocational guidance specialists and similar rehabilitation personnel, as well as with the professional schools of physical and occupational therapy. It should have strong liaison with the State Division of Vocational Rehabilitation and other public and voluntary medical, vocational training, casework, sheltered workshop, placement and similar specialized rehabilitation agencies.

The Division of Vocational Rehabilitation of the State Department of Education is required by law to promote vocational rehabilitation of persons disabled in industry or otherwise. For some years Massachusetts has ranked near the bottom of the list of the 48 states in the per capita expenditure of state funds for vocational rehabilitation (excluding appropriations for services to the Blind). This weakness of State action not only means that the residents of Greater Boston and the remainder of the Commonwealth are not receiving the same rehabilitation services they would receive in other States (for which the Federal government will assume a major share of the costs), but that local direct service agencies are not being reimbursed for services rendered to clients who are eligible for and should be receiving such services through the State Division of Vocational Rehabilitation. This situation places an undue burden on the direct service agencies which must appeal to the Greater Boston Community Fund and other sources of voluntary funds. Therefore —

We Recommend that consideration should be given to an increase in budget and staff, and a more liberal policy in determining eligibility and feasibility for training, by the Division of Vocational Rehabilitation of the Department of Education of the Commonwealth.

Chronic illness with its resultant physical disability is becoming a primary medical problem of Greater Boston, as of the nation. With our greatly increasing age level we can expect an increasing incidence of such disability. Medicine must turn more and more to rehabilitation and physical medicine to train persons so afflicted to live and work as effectively as possible. Such rehabilitation is justified, whether it restores such persons to economic self-sufficiency, or only enables them to care for themselves and do productive work while still living in a hospital. Therefore —

We Recommend that rehabilitation facilities and services stressing self-care should be extended at once in Long Island Hospital, public and private nursing homes, infirmaries and other institutions caring for the chronically ill.

*Pertaining to the Improvement of Referral, Information and Liaison Agencies Serving the Handicapped*

Cases are not referred sufficiently early, nor is there adequate inter-agency planning for the handicapped in Greater Boston. This point is amply supported by illustrations in our full Report and our Summary Report on Rehabilitation Services, Voluntary Casework Division. The need for a central information and referral service in this field has long been recognized. Pending organization of a general information and referral system dealing with all types of health and welfare services, the most appropriate organization to conduct such a central information and referral service for the handicapped is the Community Workshops. Therefore —

We Recommend that (1) The Community Workshops should establish an information and referral service, dealing with rehabilitation services available to the community as a whole, and operate such service until it can be incorporated into a general information and referral service; (2) the proposed Federation for family service should establish an effective working relationship with the Community Workshops; (3) inter-agency relationships in all matters having to do with the handicapped should

be strengthened by strengthening the Rehabilitation Section of the Greater Boston Community Council; (4) rehabilitation counselors trained in vocational guidance for the physically handicapped should be utilized by each large hospital in the Area (preferably as a hospital staff member) and by the Industrial Accident Board; and (5) in all rehabilitation programs, professionally trained personnel should be utilized.

*Pertaining to the Strengthening of Existing Programs and Agencies, New Services, and to the Reorganization and Dissolution of Agencies.*

As a result of the gains made in rehabilitation techniques during and since the war, there has been a growing interest in the development of a rehabilitation center in Boston. The Community Workshops has recently enlarged its program to include physical therapy, but it does not appear that these additional services have met the need for a rehabilitation center. There has recently been organized the Bay State Medical Rehabilitation Clinic, which plans to operate a physical rehabilitation center to serve adults over 16 years of age. We believe this center is needed; but we think that, at least in the beginning, the clinic should limit its service to providing treatment and training on a fee-for-service basis for patients referred by private physicians, insurance companies, the Industrial Accident Board, the State Division of Vocational Rehabilitation and other fee-paying agencies. Because of the outstanding experience of certain staff members of the Bay State Medical Rehabilitation Clinic in the field of prosthetic devices, we believe the proposed center will become the focal point in the community for the fitting of prosthetic devices and for training in their use. Therefore,

We Recommend that (1) support should be given to the proposed Bay State Rehabilitation Clinic for the physical rehabilitation, on a fee-for-service basis, of adult patients referred by private physicians, insurance companies, the Industrial Accident Board, the Division of Vocational Rehabilitation and other fee-paying agencies; (2) the physical therapy services and definitive occupational therapy services of Community Workshops should be continued only until such services are taken over by the proposed rehabilitation and physical medicine service at Boston City Hospital and by the Bay State Medical Rehabilitation Clinic; (3) the homebound occupational therapy services of the Visiting Nurse Association of Boston, which have been discontinued, should be assumed eventually by the proposed rehabilitation and physical medicine service at Boston City Hospital and by the Bay State Medical Rehabilitation Clinic; (4) an in-hospital rehabilitation service should be established at Boston Sanatorium; (5) the post-hospital rehabilitation services of the Boston Tuberculosis Association should be strengthened and its activities should be integrated with those of the Sheltered Work Shop, the Division of Vocational Rehabilitation of the Commonwealth of Massachusetts, the Boston City Department of Health, Boston Sanatorium, and the Massachusetts Tuberculosis and Health League's activities in rehabilitation; (6) Morgan Memorial Goodwill Industries should continue their present service of providing temporary employment and sheltered work to physically handicapped clients, should continue present plans to increase their vocational training services for the physically handicapped, but should not consider starting additional therapeutic or medical programs; and (7) an employment program for the homebound should be developed under the direction of Community Workshops,

The work of the Bureau of Occupations for Handicapped Women of the Women's Education and Industrial Union duplicates the services provided by casework agencies, the Massachusetts State Employment Service, Morgan Memorial, Community Workshops and the State Division of Vocational Rehabilitation. Therefore —

We Recommend that the Bureau of Occupations for Handicapped Women of the Women's Educational and Industrial Union should adopt a policy of referring *new* applicants to appropriate agencies.

Although services to the hard of hearing and services to the deaf have, in many instances, been maintained as separate services, such separation has been largely the result of tradition and the development of specialized interests. Because many of the basic services needed by both groups are identical, it is believed that such services can be most economically and effectively administered by one agency, with such divisions as will recognize any special or different needs of groups to be served. The Boston Guild for the Hard of Hearing appears to be the logical nucleus. Additional agencies for the deaf and hard of hearing should be discouraged. Therefore —

We Recommend that (1) Proposals for additional agencies for the deaf and hard of hearing should be dropped, and additional services and facilities for the hard of hearing should be organized within the framework of existing agencies; (2) the Sarah Fuller Foundation for Little Deaf Children should, under appropriate legal proceedings, be merged and consolidated with the Boston Guild for the Hard

of Hearing, thus uniting the staffs and services of these agencies and making possible the more economical use of professional staff.

The Lend A Hand Society is primarily a fund-disbursing agency, granting funds for vacations, convalescent care, prosthetic devices and similar direct services, for persons referred by social agencies. Its work extends beyond Massachusetts and the United States. It is believed that its services within Greater Boston can be done more economically and satisfactorily by agencies rendering direct services to clients.

We Recommend that the functions and responsibilities within Greater Boston of the Lend A Hand Society, other than the work of its Church Clubs, should be assumed by other agencies.

We Further Recommend that (1) the Massachusetts Branch of the Shut-in Society, Inc., should affiliate with Community Workshops, as through such affiliation the services now being given by said Massachusetts Branch can be rendered more effectively and economically; (2) the Bay State Society for the Crippled and Handicapped should continue in its present role of fund-raising, public education, stimulation of professional education and financial grants to direct services agencies; and (3) this agency should operate direct services only as long as there are obvious needs to be met which do not logically fall within the scope and function of other existing voluntary or tax-supported agencies, such direct services continuing on a demonstration basis, (a) until the service has served its purpose, or (b) until other voluntary or tax-supported agencies are in position to take over.

Special Note on Services to the Blind

No specific recommendations are submitted on services to the blind. Such services were observed to be much more complete and of higher quality than services to persons suffering from other forms of handicaps. This is true not only in Greater Boston but generally throughout the country. It is not implied that the blind are perfectly served, nor that constant effort should not be made to improve and extend the service they receive; but the general condition of services to the handicapped in Greater Boston, and the limited amount of money available, clearly dictate that, for the present, major efforts should be directed toward bringing services to other groups of handicapped persons up to the quality of services now given to the blind.

Our full Report on Rehabilitation Services contains considerable discussion of the work of the State Division of the Blind. Our judgment is that the placement program of the Division does not appear to be as aggressive and satisfactory as is desirable, and it could advantageously be strengthened.

## 7. *Medical Social Service*

The influence of Boston in the growth of medical social work is recognized throughout the world. Visitors from all parts of the globe have been coming for four decades to observe and study the first developments here; beginning with the early writings of Dr. Richard Cabot, important medical social work literature has been written here; and large numbers of medical social workers in key positions all over the country gained their early knowledge and experience here. In spite of having been a pioneer in medical social work, Boston now betrays among its agencies a lack of knowledge of the field, a degree of misunderstanding, and frequently a highly critical attitude concerning various phases of the work, on the part of board member and other lay groups and within professional social work groups themselves, such as is not found in many other large cities.

*What Medical Social Work Is*

Medical social work in hospitals and other medical care agencies has as its primary purpose the provision of social casework service to persons who have social and emotional problems associated with illness. The functions of the medical social work department are the practice of social casework; teaching; research; and, more recently, active collaboration in various phases of community planning for health and medical care resources.

*Better Inter-agency Relations Needed*

The main purpose of the Survey in this field was to study the organizational problems of inter-agency relationships and practices. We found them in serious need of improvement. Because it is so important that relations between medical social services and other casework services be strengthened:

We Recommend that a Medical Social Work Section should be established in the Family and Child Care Division of the Greater Boston Community Council; that representation of the medical social work field should be provided for in the Health and Hospitals Division of the Council; and that the

Council should appoint a Medical Social Work Consultant to its staff. (The chief duties of such consultant are set forth in our full report on Medical Social Services — Voluntary Casework Division.)

Our Divisional Reports on Family Casework Services and Voluntary Child Care Services describe the effect of inequitable distribution and duplication of these services and their lack of accessibility to those needing them. Nowhere has this situation caused more confusion, or more suffering, than among patients of hospitals, and no group has raised more questions as to the effect of the present system than have medical social workers. The specialists who prepared our Report on Family Casework Services recommend the appointment of a Medical Social Work Consultant on the staff of the proposed Federation of family services. Our specialist in medical social work, viewing the same situation from her standpoint, makes the same recommendation.

*Uneven Distribution of Medical Social Work*

Medical social service is unevenly distributed throughout Greater Boston. To reveal the full nature and effects of this maldistribution of a valuable service —

We Recommend that the Greater Boston Community Council should make a study of the coverage and distribution of medical social service in Greater Boston.

*Other Resources Needed by Medical Social Work Departments*

All needed community resources should be accessible to medical social work departments. To this end —

We Recommend that Medical Social Work Departments of hospitals and other medical care agencies should clear through the Medical Social Work Consultant of the Community Council all difficulties in the way of obtaining needed casework or other services.

*The Needs of Sick Children*

There is particularly low coverage of medical social casework services available within hospitals offering medical care to children; more than half of these hospitals have no medical social work department. As long as this situation continues, an important source of early case-finding in the child care field remains unreachable, leaving to chance the possibility that these children and their parents will find casework or other service to assist them. Without the channeling of many of these children to appropriate agencies when their problems are less acute, the community is in the position of offering a medical service that frequently is palliative and frustrating to the patient, the family and the doctor, and extravagant for the hospital and the community.

We Recommend that the Greater Boston Community Council should undertake a study of the problems of foster home care for sick children; and that the study of the coverage and distribution of medical services recommended above should include a searching review of the needs of sick children.

*Medical Social Work and Adoptions*

Adoptions and services to unmarried mothers should be concentrated in appropriate child care agencies. Medical social work departments of hospitals should not engage in these services. The essential nature of the service needed by unmarried mothers in assisting them to meet their life problems, including decisions regarding the baby, is clearly social work service. In these situations, advice given to unmarried mothers by well-meaning physicians, clergy, nurses, or others may be and often is harmful, as can be seen in the records of many district attorneys' offices and courts.

We Recommend that hospitals having a maternity service should establish desirable and protective practices for all unmarried mothers, and should encourage the practice of referring all unmarried mothers for casework service to their medical social work departments; that adoption services should be strengthened as proposed in the Report on Voluntary Child Care Services; and that all child care agencies directly related to the adoption field should assume full responsibility for services needed to put these recommendations into effect.

*Personnel Practices*

Our Hospital Division Report recommends that a study of personnel practices for hospital employees, including nurses, be undertaken by the Hospital Council. The marked differences in salaries, as between medical social work departments of hospitals and voluntary casework agencies requiring staff of the same degree of professional training and competence, create great difficulties in the recruitment of medical social work staff, therefore —

We Recommend that medical social work positions should be included in any general study of hospital salaries.

*Areas of Responsibility*

Areas of responsibility for financial aid to patients and their families, after the discharge of such patients from hospitals, should be defined. At various stages in the preparation of a patient for medical or surgical care, or during his stay in hospital, or immediately following his discharge, occasion arises for the expenditure of money for what is known as medical relief. At present, medical social service departments having no funds of their own must seek funds through agencies which are often reluctant to accept such referrals; or the social service departments must spend valuable time in soliciting small societies and other groups which have relief funds available. The families of such patients, frequently because of the patients' illness, have need of financial assistance or supportive casework services. Responsibility for help to these families, as well as direct help to the patients, is too often a matter of uncertainty and debate. In the case of the families, it is clear that responsibility for assistance should be accepted by family agencies. In both cases the issue should be resolved by agreement. Therefore,—

We Recommend that (1) medical social service departments of hospitals and family service agencies, through the Greater Boston Community Council, should agree on the groups of patients to be served by each kind of agency; (2) medical social service departments of hospitals should have funds available for medical relief expenditures; (3) hospitals should include within their budgets allowances for expenditures by social service departments, in keeping with the areas and forms of service agreed upon through the Council, as the responsibility of medical social service departments.

*Need of Better Understanding*

As noted earlier in this report, too many doctors, hospital board members, board members of other social agencies, contributors to the Greater Boston Community Fund, and even professional social work groups, have too little understanding of medical social service.

We Recommend that a planned program of interpretation of the field of medical social work should be set up under the direction of the Public Relations Department of the Greater Boston Community Council, in consultation with the Medical Social Work Consultant on the Council staff and the staff of the Hospital Council.

## *8. Services for the Unattached, Homeless, and Transient*

Legal responsibility for providing the basic services for indigent homeless, as for other dependent persons, falls on departments of public welfare. In Municipal Boston, however, many voluntary agencies render substantial service to the homeless, unattached and transients. Some of these agencies specialize in service to such persons; some are family agencies whose caseload always contains a proportion of indigent homeless. There is a general agreement that all agencies refer resident homeless men to the Industrial Aid Society, but this agreement is not always observed. In the Metropolitan Area, there are no voluntary agencies specializing in service to the homeless, but family agencies there serve many such persons. Referrals of homeless cases from family agencies to specialized voluntary agencies are frequent but are not always accepted, with the result that a homeless person may go from one voluntary agency to another without receiving help, and may finally get some form of help from a public agency, which has had legal responsibility for him all along.

Nowhere is there evidence that a satisfactory division of responsibility has been achieved in the use of tax and voluntary funds in the provision of relief to the indigent homeless. Unless some over-all agreements can be reached, homeless and transient persons will continue to be caught in the mesh of ineffective community planning. Apart from the issue of sheer justice to this unfortunate group of people the stake of voluntary agencies in the question is large, as many thousands of dollars of voluntary funds can be identified as having been spent for the relief of the homeless, with additional services rendered to them by family agencies and the Society of St. Vincent de Paul, at a cost less easily measurable but known to be considerable.

We Recommend that the Greater Boston Community Council undertake at once to work out agreements between agencies in this field clearly defining their responsibilities, such agreements to be based on the legal responsibilities of public agencies; that voluntary agencies should stop rendering the kinds of service that are the responsibilities of public agencies, confining their work to that which cannot be rendered by public agencies; that the Greater Boston Community Fund make no allotments

for any additional institutional or custodial facility in this field; and that the Greater Boston Community Council work for the establishment of a Central Application or Intake Bureau in the Boston department of public welfare, to which all unattached, homeless and transients can be referred.

We discuss below the major voluntary agencies which are active in this field of service.

*Industrial Aid Society*

At present, the Industrial Aid Society (established in 1835) endeavors, by casework, counsel and relief, to give to unattached men a sort of service paralleling that of private family agencies.

The work of this agency is in part a job that should be performed by the Boston public welfare department. Public opinion should insist that the public agency discharge its legal responsibility for such work. Of the cases handled, so many (75-80 percent) have serious problems of alcoholism, coupled with repeated conflict with the law, and so many (65 percent) are over 40 years of age, that we are justified in inferring a rather fixed pattern of maladjustment. Such cases call for the service of a highly skilled staff, psychiatrically and medically trained, and should be referred to agencies so equipped. The agency's present personnel cannot provide the kind of treatment required. The justification for the continued existence of the agency is questioned.

WE RECOMMEND that the Industrial Aid Society should be discontinued as soon as the orderly transfer of its functions and caseloads can be accomplished; that the Greater Boston Community Fund should materially reduce its allotment to the Society during 1949, and not make an allotment for any period after December 31, 1950; and that the Society should transfer its funds and assets through appropriate legal action to the proposed Federation for family service and to other voluntary special service agencies providing the type of care or treatment needed by the unattached and homeless.

WE FURTHER RECOMMEND, that, prior to the closing of the Industrial Aid Society, its caseload under care be carefully screened by a competent team of medical and social work personnel to determine (1) cases that should be referred to the public welfare department; (2) cases that should be referred for qualified medical and or psychiatric treatment; and (3) cases that should be referred to casework agencies for casework treatment.

*Morgan Memorial* (Fred H. Seavey Settlement)

Analysis of the work of this agency (given in our full Voluntary Casework Division Report (Services to the Unattached)) discloses that a heavy proportion of its caseload consists of alcoholics, which the staff is not equipped to deal with; and that the facilities and subsistence which it provides fall largely within public agency responsibility. In view of these facts:

WE RECOMMEND that the work of the Fred H. Seavey Settlement of Morgan Memorial should be discontinued; and that the Greater Boston Community Fund should materially reduce its allotment for use by this Settlement during 1949 and not make an allotment therefor for any period after December 31, 1950.

WE FURTHER RECOMMEND, that, prior to the closing of the Settlement, its caseload should be screened by a competent team of medical and social work personnel to determine (1) cases that should be referred to the public welfare department; (2) cases that should be referred for qualified medical and or psychiatric treatment; (3) cases that should be referred to casework agencies for casework treatment; and (4) cases that should be retained in the rehabilitation program of the Morgan Memorial Goodwill Industries.

*Travelers Aid Society, Inc.*

This agency's essential function is to provide transportation and casework assistance to individuals and families in transit or temporary residence in Boston. This function gives the agency a clearly delimited area of service. Because it is a well known agency, however, it receives applications for assistance from many people whom it was not established to serve, and is thus forced to make many referrals. Its effectiveness, therefore, depends to a large extent on the organization of the community's tax-supported and voluntary agencies which, at one level or another, are also engaged in work with homeless and transient persons. In the present confused condition of services dealing with the homeless and transient, the Travelers Aid Society spends considerable time and some cash for relief purposes in its efforts to get applicants to the proper agency.

WE RECOMMEND that the Travelers Aid Society discontinue payment for subsistence, lodging or other maintenance needs where such needs are not directly related to its primary function. Commencing

with 1950, the allotment of the Greater Boston Community Fund to this agency should be reviewed in the light of this and other recommendations in this and other Survey Reports. For 1950 and thereafter, Fund allotments should be based upon support of the agency's exercise of its primary function.

*The Boston Industrial Home*

This agency (not a member of the Greater Boston Community Fund) is a resource of some importance because it has the capacity to provide shelter for about 100 homeless persons. It is used by both Fund and tax-supported agencies for temporary shelter referrals. It provides overnight accommodations and meals, at a modest charge, and many of the persons it serves are alcoholics. It appears to operate as in the long past, without recognition of the present role of public assistance or of the fact that so large a percentage of its clients have serious personality problems which call for skilled professional help.

Realizing its situation, the agency has recently suggested that it might dispose of its physical properties, use the proceeds and its endowment funds to acquire and improve the Dawes Hotel, and thereafter rely on Community Fund allotments to finance an operation for sheltering homeless persons. Such a proposal runs counter to the sound principle that basic care of homeless persons is the responsibility of tax-supported agencies.

We Recommend that the Board of the Boston Industrial Home withdraw from its present area of service, which is the responsibility of the public welfare department, liquidating its own operations accordingly; that it refer the balance of its clients to appropriate tax-supported and voluntary agencies; and that thereafter it liquidate in fact as a corporate body, using its influence and financial resources to encourage existing tax-supported and voluntary agencies to meet the needs of homeless and transient persons in accordance with the recommendations of this report.

In view of the amount of actual or suspected alcoholism in the caseloads of some of the agencies discussed above,

We Recommend that the Greater Boston Community Council undertake further study of the need and the facilities for the treatment of alcoholism in the Greater Boston Area.

## 9. *Services to Seamen*

Care of indigent seamen is the legal responsibility of tax-supported agencies. Voluntary agencies should not be expected to provide more than the recreation and fee shelter service they are now providing for seamen. Most voluntary agencies serving seamen lack the desirable social service orientation of other agencies. But popular interest in seamen and concern for their welfare has a long history in Boston and its roots are deep. Existing voluntary agencies in this field serve a useful purpose. They should exert themselves, however, to work with agencies possessing trained staff in obtaining services which they themselves are unable to provide.

We looked at the program of four voluntary seamen's agencies in the light of the foregoing considerations.

One of these four, the Lutheran Seamen's Home, had recently come to realize that an increasingly large number of the men it was caring for were neither Lutherans nor seamen; and the agency itself raised the question of whether its services were needed. In the course of a discussion between representatives of the agency, the Greater Boston Community Council, and the Survey, it was agreed that the Lutheran Seamen's Home should discontinue its operations.

Two other seamen's agencies looked at are the Boston Seamen's Friend Society and Mariners' House, a non-Fund agency. Boston Seaman's Friend Society has stations in Boston and at Vineyard Haven; Mariners' House, in Boston only. The two agencies enjoy a cooperative and friendly relation, each availing itself of the other's facilities if its own are taxed beyond capacity. The staff of neither is "trained" in the modern sense, but has long experience in working with seamen.

We Recommend that both agencies should continue their work in Greater Boston, in the case of Mariners' House without requirement of Fund support; that Boston Seaman's Friend Society should discontinue its activities outside of Greater Boston; that both should utilize the services of other agencies in meeting the needs of clients which their present staffs are not equipped to meet; that the staffs should discuss the work and problems of their agencies with the representatives of casework agencies through the proper Division of the Greater Boston Community Council; and further that, in view of the close working relations between the agencies, they should explore the economies and increased efficiency which should result from consolidation under a completely unified direction and management

The fourth seamen's agency we looked at was the Seamen's Club, a non-Fund agency operated by the Episcopal City Mission. It has a good program, but one which duplicates in some respects that of the Boston Seaman's Friend Society. Its new location, however, near South Station, is such that it serves seamen and military men who might not find their way to either the Seamen's Friend Society or the Mariners' House.

We Recommend continuance of the present services of the Seamen's Club; but believe that, because of its new location, a close watch be kept of the volume of its work, so that the cost of service does not become out of proportion to the number served. If this number becomes too small, the agency should consider discontinuance or consolidation with other agencies serving seamen. It should utilize the services of other agencies to meet the needs of clients which it is not equipped to meet.

## *10. Social Service Index*

The Social Service Index is a cooperative service conducted by the Greater Boston Community Council. It maintains a central index to the files of member agencies for their convenience in consulting one another's records. Its policies are increasingly formulated by a Council Committee composed of lay and professional representatives of the largest users of the Index and of all appropriate functional fields. It is desirable for the Index to move in this direction, for it can best serve the interests of its member agencies only when those agencies themselves have major responsibility for shaping its policies.

The Index is housed in a building occupied by the Overseers of the Public Welfare in the City of Boston. The Index pays no rent for its quarters, and in exchange for this privilege provides free case-clearing service to the Board of Overseers. We regard this as an unsatisfactory arrangement, because it does not reflect a clear cut relation between the cost of service rendered and payment for that service. It is generally held that the costs of an Index should be borne by the agencies that use it, the amount paid by each agency bearing the same ratio to the total operating costs of the Index that the service received by the agency bears to the total volume of service rendered by the Index. The Council's Committee on the Index is studying the problem of financial support for the Index to the end that an improved and more uniform policy may be worked out; and expects shortly to propose a plan embodying the principle outlined above.

It is important that such a plan be adopted, for the Greater Boston Community Fund is now paying, on behalf of its member agencies that use the Index, a disproportionately high percentage of Index costs, as is shown in the two following tables:

Total Expenditures of Social Service Index and Amount Paid by Groups of Agencies using the Index in 1945, 1946 and 1947.*

| Item | 1945 | 1946 | 1947 |
|---|---|---|---|
| Total Expenditures | $31,250 | $37,795 | $45,335 |
| Amount Paid by: | | | |
| Tax-supported agencies | 9,562 | 10,373 | 10,459 |
| Voluntary non-Fund agencies | 3,795 | 4,415 | 4,206 |
| Fund agencies | 17,893 | 23,007 | 30,670 |

*Not including any payments of rental for quarters, which are provided rent-free by the Overseers of the Public Welfare in the City of Boston.

Units of Service to Groups of Agencies by Social Service Index, 1945, 1946 and 1947

| Agencies | Units of Service 1945 | 1946 | 1947 |
|---|---|---|---|
| Total | 91,303 | 101,141 | 98,211 |
| Tax-supported | 38,872 | 52,116 | 53,115 |
| Voluntary non-Fund | 21,497* | 20,100* | 18,426 |
| Fund | 39,934* | 28,925* | 26,670 |

*Estimated.

For the reasons set forth —

We Recommend continuance of a suitably composed Council Committee on the Index, with authority to formulate, subject to approval by the Council's Board of Directors, all Index policies; adoption of a policy of financial support of the Index in conformity with the general principle of index financing set forth above; establishment by the Index Committee of job specifications for the Index staff; and definite administrative responsibility of the Director of the Index to the Executive Director of the Council.

# VI. Recreation and Group Work Services

## *General Considerations*

### *Planning a Community Program*

*The Need for a Community-Wide Program.* In this part of our report, as in other parts, emphasis is placed on the development of a community-wide program of recreation and group work services embracing both tax-supported and voluntary agencies; on central thinking and planning affecting the total community; and on decentralized operation in accordance both with this central thinking and planning and also with traditional agency operation in so far as that may fit into the central thought and plan.

In World War II cooperative joint planning and operation of a community program of recreation and group work services was a fact. Six large national agencies, joining together under the banner of the U.S.O., learned that it was possible to plan and work together in accordance with common policies and procedures on the national and local level and, when desirable, under the same roof. They learned that it was possible to work cooperatively with governmental agencies to the same common end. The realized experience of joint planning and operation in this field is possible of further extension in peace, as well as in war. Isolation and imperialism are today as reactionary at the community level as in world affairs. In a free society like ours the philosophy of "one community" should prevail.

We should, therefore, seek to develop a community-wide program through cooperative joint effort of all agencies, both tax-supported and voluntary. Thoughtful leaders recognize this great need and stand ready and willing to contribute their best effort to this end.

*Some Guiding Principles.* Certain lessons drawn from general experience in the development of recreation and group work programs can be briefly summarized. These basic principles will serve as guides in the planning of a community-wide program of these services. Each of these principles is discussed in some detail in our full Report on Recreation and Group Work Services.

(1) One of the basic needs of modern community life is that opportunities for play, recreation and group experience be provided for children, youth and adults regardless of their economic or social status.

(2) Given suitable facilities and qualified leadership, including cultural and social qualifications, it is possible for any agency, whether tax-supported or voluntary, to do an adequate basic job in organizing and directing programs of play, recreation and group experience.

(3) The development of qualities of good citizenship and the promotion of neighborly association and civic responsibility are requirements for any agency organizing and directing programs of play, recreation and group experience.

(4) The primary responsibility of the tax-supported agency in providing programs of play, recreation and group experience is to provide a background of facilities, qualified leadership and services on a community-wide basis (as, for example, in libraries, museums, parks, playgrounds, and school and other municipal buildings.

(5) The primary responsibility of voluntary agencies in providing programs of play, recreation and group experience is to develop, against the background provided by tax-supported agencies, their own voluntary programs in order to meet the special needs of groups.

(6) A community-wide program of play, recreation and group experience represents the sum of all programs financed by the community dollar, which is made up in part by money secured through the tax levy and in part by money secured through voluntary contributions, and this program should, therefore, represent the wisest expenditure of this dollar.

(7) A central coordinating device, established by the voluntary cooperative effort of people of good will in the community, which is recognized and accepted by all agencies as the center for community planning, in accordance with generally accepted and established principles, is essential if the wisest expenditure of the community dollar is to be attained.

*The General Character of the Area.* In this study the 15 Health and Welfare Areas of the City of Boston and the 5 Metropolitan Divisions of the Area, as established by the Greater Boston Community Council and Greater Boston Community Fund, are taken as the geographic units for consideration.

The Index of Social Need shows the areas of greatest need as being 9 of the Health and Welfare Areas of the City of Boston and 3 communities in the Metropolitan Area (Chelsea, Cambridge, and Burlington). The areas with greater than average need include 4 of the Health and Welfare Areas of the City of Boston and 11 Metropolitan cities and towns, largely on a north and south axis through Boston. The areas of average need include one Health and Welfare Area in the City of Boston and 14 Metropolitan cities and

towns. One Health and Welfare Area of Greater Boston and 13 Metropolitan cities and towns have less than average need and 13 cities and towns are shown to be of least need. Thus it is seen that 13 of the Health and Welfare Areas of the City of Boston have a need, according to this Index, greater than average. Only 27 areas out of the 69 have less than average need.

The significance of these findings for this study rests primarily in the fact that within the City of Boston there is so little variation in the Index of Social Need for the majority of Health and Welfare Areas as to indicate little priority of recreation and group unit service for the different Areas.

It may be true that some *neighborhoods* within these Areas will show a greater social need, based upon other factors than those used in the Index of Social Need referred to above. Still, with general conditions as they are throughout these Areas, it is difficult to accept the validity of an approach based upon a *neighborhood* analysis of this kind. It seems more practical to accept the uniformity of conditions as indicated by this Index and proceed with a plan which is based upon an organization of service with a wider spread than the neighborhood. The projection of such a plan will mean some sacrifice of intensive services, as now provided in some neighborhoods, in the interest of utilizing existing resources to secure basic coverage of wider areas. It will require both tax-supported and voluntary agency resources to be largely utilized in providing a background of basic facilities, leadership and service. In this way, existing resources will make a greater return to the people, and the foundation built will be one which will facilitate sounder growth for the total program.

*The General Character of Agency Approaches.* The Table which follows gives some indication of the number of *agencies* providing programs of play, recreation and group experience in the Greater Boston Area (the number of separate *units* of those agencies is much larger). The agencies are listed by type of program. The table also shows the total expenditures for each classification of agency.

Number of Public and Voluntary Agencies and Expenditures for 1946 by Type of Program

| Type of program[1] | Number of Agencies | | | 1946 Expenditures | | |
|---|---|---|---|---|---|---|
| | Total | Public | Voluntary | Total | Public | Voluntary |
| Total | 239* | 57 | 182* | $7,118,231 | $2,516,086 | $4,602,145 |
| Community-wide building-centered | 27 | — | 27 | 1,480,074 | — | 1,480,074 |
| Neighborhood building-centered | 54 | 2 | 52 | 1,456,009 | 107,982 | 1,348,027 |
| Neighborhood non-building centered | 53 | — | 53 | 311,260 | — | 311,260 |
| Playground and general recreation | 60 | 55 | 5 | 2,532,886 | 2,408,104 | 124,782 |
| Established summer camp | 40* | — | 40* | 1,023,450 | — | 1,023,450 |
| Other | 5 | — | 5 | 314,552 | — | 314,552 |

Excluding the 40 camps from the total of 239 agencies shown in the above table, because these camps are largely operated by agencies with other recreation programs, we find roughly 200 public and voluntary agencies in this Area to be engaged in organizing and directing some phase of a program of play, recreation and group work. Within Municipal Boston there are 11 agencies conducting community-wide building-centered programs and 36 agencies conducting neighborhood building-centered programs, with a total of 71 different buildings in use. Twenty-six of these buildings are operated by tax-supported agencies. Furthermore, the Public School Department during certain seasons of the year operates 97 play-grounds which are primarily neighborhood-centered. The Boston Park Department operates 108 playgrounds with varied seasonal programs; 128 miles of bridle paths, walks and driveways for hiking, horseback riding and like activities; two 18 hole golf courses; two toboggan slides; a sailing program; a swimming and life-saving program at 9 bathing beaches; two solariums; two indoor swimming pools; twelve indoor gymnasiums; a garden program in Woburn; home garden programs, etc. In addition to these services, the Park Division of the Metropolitan District Commission controls 11,381 acres of park area located in 22 cities and towns; 1,560 acres in parkways reaching 117 miles throughout the Area; 144 miles of bridle paths; 91 facilities, including 2 golf courses, 20 beaches and 29 picnic areas, which serve individuals, families and groups from a wide area; and 41 other facilities for local use in 21 cities and towns in the Area.

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[1] Agencies classified as "*community-wide building-centered*" provide group work or recreation services to the population of a large geographic area, — for example, the YMCA in buildings usually owned and operated by the agency. Agencies classified as "*neighborhood building-centered*" provide services, in buildings usually owned and operated by the agency, to persons living in the vicinity of the agency, — for example, Settlements and Boys' Clubs. Agencies classified as "*neighborhood non-building-centered*" serve persons of a neighborhood or small geographic area, — for example, the Scouts. "*Playground and general recreation*" agencies include such agencies as park departments, recreation boards and commissions, and similar organizations providing facilities or programs for large numbers of people. Agencies classified as "*established summer camps*" provide a summer camp program for longer periods than overnight or week ends.

*Includes some duplication of agencies since most camp programs are run by agencies with other recreation or group work programs.

Quite obviously, what is found in the Greater Boston Area today is a pattern typical of the development of recreation and group work services in communities where progress has gone forward on a piecemeal basis, in response to significant changes in the whole movement of recreation and group work. Without the aid of a periodic review of the total development, whose prime purpose would be a consolidation of gains and the staking out of new guides and direction posts for future operations, this is a natural, indeed an inevitable result.

*A General Analysis of the Program As Related To The Seven Basic Principles.* Using as criteria the Seven Basic Principles above set forth, some interesting generalizations can be made which point up major weaknesses of the Greater Boston Area program as it now exists.

*Principle (1)* states the need for providing opportunities for play, recreation and group experience for people of all ages, regardless of their economic or social status. It is quite possible for some people to satisfy their need for these opportunities within the limits of their own resources, but in any community the great mass of people can secure these opportunities only as participants in community supported programs.

As developed at length in our full Report on Recreation and Group Work, Municipal Boston *alone* has a total of 352 different recreation and group experience *program centers*, or an average of 23 for each Health and Welfare Area. Certainly no thoughtful person would maintain that this number of such program centers is essential. The similar pattern, throughout the Greater Boston Area, is the result of years of accumulation and ineffectual total planning and is now sustained at enormous cost to the community. In the whole Area expenditures in this field in 1946 exceeded $4,000,000, a figure probably not complete.

*Principle (2)* states that it is possible for any agency, given suitable facilities and qualified leadership, to do an adequate basic job in organizing and directing programs of play, recreation and group experience. The basic requirement here is opportunity to pursue one's interests and use one's skills in an acceptable cultural and social pattern in order to secure the personal satisfactions sought. Accordingly, facilities and leadership are important considerations, as they influence the tone of the environment and the quality, attractiveness and appropriateness of the opportunities presented. If these factors are comparable or equal, agency auspices are relatively unimportant except as they may contribute to specific values associated with different agency programs. The existing program in the Greater Boston Area, particularly in the City of Boston, and with respect to service in geographic areas, gives evidence that this principle has not been recognized, or it has been disregarded in favor of a practice which gives undue weight to agency location and auspices. To the extent that this is true, the cost to the community has been increased.

*Principle (3)* states that the development of qualities of good citizenship and the promotion of neighborly association and civic responsibility are requirements for any agency organizing and directing programs of play, recreation and group experience. Even though this principle is generally recognized, it is often contended that certain agencies are peculiarly qualified to do a better job in these respects than other agencies. To the extent that the program of any agency is focused exclusively on the values stated in this principle, this may be true. However, in considering a distribution of opportunities, it should be clear that it is not necessary to have a separate Neighborhood House or Boys' Club in every Area in order to assure realization of these values in such Area. And certainly five Neighborhood Houses or Settlements in the same area, as we find in the South End of Boston, are not needed to guarantee these results. The main requirement is an agency with a proper program.

*Principle (4)* states that the primary responsibility of the tax-supported agency is to provide a background of facilities, qualified leadership and services on a community-wide basis. This responsibility is discharged chiefly through provision of parks, varied programs centering in the public schools, the activities of Recreation Commissions and Planning Boards, the use for recreational and group experience purposes of municipal buildings, libraries, and museums. In our full Report we give a brief appraisal of what has been done in Greater Boston through each of these channels. From that summary, it is obvious that there now exist a great many resources of facilities, leadership and service which the tax-supported agencies should and can provide in a community-wide program of play, recreation and group experience. The extent to which these obvious potentials can be realized would appear to depend solely on the effort directed to this end. Every factor indicates that a strong effort is desirable and essential if "the charitable dollar annually raised in Greater Boston is to do the greatest good for the greatest number in the most economical, effective way."

*Principle (5)* states that it is the responsibility of voluntary agencies to build against the background provided by the tax-supported agencies in order to meet the special needs of groups. Again in our full

Report we give fairly detailed consideration to the existing situation of voluntary agencies in Greater Boston, with a view to determining the direction their program should take in the future in order to discharge this responsibility. This discussion in our full Report may be summarized as follows:

a. Voluntary agencies in the Area are well equipped both in purpose and experience to move ahead doing exploratory and demonstration work of great value to the community program of play, recreation and group experience.

b. Due to the variable pattern of facilities, leadership and services provided by the tax-supported agencies, there will be constant need for the voluntary agencies to accept responsibilities which, although properly belonging to the tax-supported agencies, are not currently as effectively distributed as they should be. In determining these responsibilities, however, there should be a careful and objective appraisal of total needs through joint planning by all agencies concerned.

c. The strength of the voluntary agencies is primarily in their leadership, their freedom to respond to varying situations, their know-how and skill in working with special individuals and groups, and their skill in leadership of small groups.

d. Acceptance by tax-supported agencies of the responsibility to provide a variety of facilities on a neighborhood, district and community-wide basis makes it less necessary for voluntary agencies to build large and expensive facilities for neighborhood and community use.

e. Community centers serving definite districts and provided by tax-supported agencies, in which public and voluntary agencies can work together, each performing those program functions it is best qualified to perform and working with those groups with whom it is best qualified to work, is the desirable goal of the future.

f. There is still need for qualified and experienced people to work on a small area basis in the discovery and interpretation of need and in promoting neighborliness and understanding.

g. Day-by-day programs of play, recreation and group experience for children, youth and families can be *organized* on a neighborhood or small area basis but *administered* and *supervised* as efficiently and more economically on the basis of larger areas.

h. Institutionalized programs (such as Boys' Clubs and Girls' Clubs) are carried on in structures that are disproportionately expensive to build, operate and maintain in relation to the people served thereby.

i. The provision of camping services for growing boys and girls is at present almost wholly the responsibility of voluntary agencies. In the interest of broader service to the community, more uniform procedures controlling camp referrals and a better budgeting process should be established and more day-camping service provided.

*Principle (6)* states that a community-wide program of play, recreation and group experience, representing the sum of all programs financed by the community dollar, which is derived from both tax funds and voluntary contributions, should represent the wisest expenditure of this community dollar. The application of this principle in Greater Boston will not be easy. There is little evidence that the expenditures of tax-funds have ever been given consideration at the time voluntary funds were being budgeted. Furthermore, there is little history of joint planning between tax-supported agencies and the voluntary agencies. It is absolutely essential, however, to apply this principle if the wisest expenditure of the charitable dollar is even to be approached.

*Principle (7)* sets forth the need for a central coordinating device which is accepted by all agencies as the center for planning, if the wisest expenditure of the community dollar is to be attained. There should be a central point, at which the planning and operation of each of the major tax-supported and voluntary agencies may be brought in review for the benefit of all the people in the community. There is no coercion or dictation or governmental control in such a proposal: i.e. that representatives of the broader community interest willingly sit down together, in mutual respect, and objectively and democratically discuss and find solutions of common problems.

Different opinions exist as to the location of this central coordinating device. Traditionally Councils of Social Agencies and Community Councils have been established as the center for social planning for the community. Elsewhere in our reports we propose a central planning body which will build on the present Greater Boston Community Council and become both more inclusive and more effective than it has been possible for the present Council to be. Here the important point to make is that an effective central planning body must include representation from tax-supported agencies. In the field of recreation and group work, the structure of the present Council is such as to exclude tax-supported agencies almost by definition. This grave defect must be remedied in order to achieve true central planning for recreation and group work.

*Findings and Recommendations*

(Special Note: So many agencies provide recreation and group work services in Greater Boston that a survey of this field is called on to make a larger number of specific recommendations than can be reasonably discussed or even quoted in a relatively brief Summary Report. All that will be possible here is to plot the main lines of reorganization we propose; to indicate the effect of that reorganization on the major agencies involved; and to refer the interested reader to our full Report on Recreation and Group Work Services for the detailed picture.)

The basic problem facing the citizens of Greater Boston in the recreation and group work field is to make certain that existing facilities dovetail together in order that their total use may provide the maximum of opportunities for people of all ages; that each agency has a qualified staff; and that each recognizes its responsibility for providing desirable results in developing qualities of good citizenship, neighborliness and civic responsibility. Our attention is perforce centered on activities in Municipal Boston, because the bulk of expenditures and operations are located there. Boston's problems are more acute and more in need of immediate attention. Our plan is in terms of Health and Welfare Areas, and similar units outside of Municipal Boston, and not in terms of mere neighborhoods. Recommendations are offered affecting services that cover all or most of Greater Boston, especially tax-supported services, as well as individual agencies outside of Boston (especially Fund agencies).

Our first three recommendations lay the ground work for all that follows:

We Recommend (1) Geographic areas should be established as the units for central planning, and the total determinable needs of each such unit should be related to its total existing resources.

(a) The Greater Boston Area is the unit for central planning by those agencies which accept responsibility for serving the entire area and can bring thereto desirable uniformity of understanding and general approach (i.e., Greater Boston Community Council, Metropolitan District Commission, Boy Scouts, Girl Scouts, Campfire Girls, Catholic Youth Organization).

(b) A local community, or a group of local communities, or a defined district of a local community (viz. the Health and Welfare Areas of Municipal Boston), may serve as a unit for central planning by those agencies which accept responsibility for serving such local community, or group of local communities or district; integrating their services with Area-wide and community-wide services which extend down into such local community, or group of local communities, or district.

(2) An efficient, economical use of the total existing resources to meet the needs of an Area is the first requirement of central planning. If supplementary resources are essential for an adequate basic program, the most efficient, economical way of providing these resources should be determined and necessary action taken to assure their provision.

(3) Qualified staff is an essential requirement for every agency organizing and directing all or parts of a coordinated program of play, recreation and group experience. This staff should recognize its responsibility with respect to the development of qualities of good citizenship, neighborliness and civic responsibility.

In proceeding to consider specific agencies, or agencies grouped together because of geographic location or the performance of like or related functions, we will begin with tax-supported agencies because it is their responsibility to provide a background or plan of facilities, leadership and services of a community-wide nature.

## *A. Tax-Supported Agencies*

### *The Metropolitan District Commission*

Because of its Area-wide services, the Park Division of the Metropolitan District Commission is first considered. In order that this body can more effectively contribute to the development of an Area-wide and community-wide program of play, recreation and group experience, additional strengths are required. These can be secured through a positive recognition of the important function this Commission can rightly perform, through a renewal of general support for its plans and work, and through some relatively minor adjustments of the Commission's organization.

We Recommend that the Metropolitan District Commission should:

(a) take leadership in the development of a comprehensive and coordinated system of park and recreation facilities in the Area, — in cooperation with the State Planning Board and other State and local park and recreation authorities, — and should employ a Supervisor of Recreation to act for it in developing and operating an Area-wide recreation program;

(b) establish the recreational use of its Park Division properties as above the police function;

(c) provide and expand day camp sites and facilities in its Park Division properties throughout the Area.

*The Boston Park Commission (The Park Department)*

Second in coverage and basic importance only to the Metropolitan District Commission is the Boston Park Department. During the last two years, this Department has made some improvement in its operations. To aid in carrying this improvement still further, we offer twelve specific recommendations. These recommendations deal with clearer assignment of staff functions; with qualifications, enlargement, and supervision of staff; with re-organization of Department units; with better budgeting procedure and methods of administration; with strengthening the playground program and the planning of the Department's entire program. For the discussion and precise wording of these recommendations, our full Report should be consulted. We believe that the carrying into effect of our recommendations will enable the Department to carry forward its programs on a sounder basis.

*The Boston School Committee*

In any community program of play, recreation and group experience, the public schools play a vital part. Properly used and deployed, their facilities and personnel are at the very heart of all that gives young people, and to an increasing extent older people as well, the qualities of good citizenship and the sense of neighborly association at which such a program aims.

Municipal Boston's school buildings, and the grounds around them, are not adequate when measured by modern school plant standards. This was demonstrated beyond any doubt in the "Strayer Report" (1944). Our own full Report spells out many of the details. Improvement of these buildings and grounds is overdue.

We believe that a wider use could be made of the existing facilities through a cooperative *planning* for such use. To make these plans the responsible School officials should sit down with representatives of the City Planning Board, the Park Commission, and the Greater Boston Community Council. Our full Report offers specific recommendations in this regard and outlines the results to be achieved.

It is a pleasure to record that the program of physical education in the Boston Schools has undergone substantial improvement in the last four or five years. In view of the importance of this program to the many thousands of children whom it affects, we think this improvement should be carried much farther; and we offer certain guiding principles and definite recommendations that we think will contribute to that end. If the Schools did their full duty in this respect, the burden of providing extensive programs of physical education now assumed by many voluntary agencies would be greatly lightened, and these agencies could devote their meager resources to important work which the School system cannot be expected to do.

The Department of Extended Use of Schools controls the use of school premises after school hours for educational and recreational activities. Such use of school properties is growing throughout the country. When our field work was done (written 1947-1948), fourteen school centers were in operation. They were doing good work; but, regarded as a whole, their programs were uneven and not coordinated either with each other or with the work of other agencies in the community. We submit specific recommendations to revitalize this operation.

*The Boston Public Buildings Department (Municipal Buildings)*

There are eleven Municipal Buildings located throughout Boston. These buildings represent the investment of hundreds of thousands of tax dollars; they contain gymnasiums, halls, meeting rooms, and in some instances swimming pools, showers, branch libraries.

Our staff was not permitted to review the records of the use of these Municipal Buildings. We understand, however, that the Public Buildings Department seems to lack a promotion program for the use of the buildings for recreation and group meetings, although it is receptive to requests for use. Such lack is serious, because many of these buildings could be exceedingly helpful in developing a well-rounded community program of recreation and group experience. The Public Buildings Department is not an agency qualified either by function or the training of its staff to control the use of these buildings for such purposes. We recommend that this control be transferred to the Park Department.

*The Board of Recreation of the City of Boston*

This Board has not had a satisfactory history. The law which created it limited its powers to planning and coordinating; hence its effectiveness could reach only as far as the regular tax-supported agencies directing programs of play and recreation would accept. This acceptance, to judge by the record, was decidedly limited.

The theory upon which Recreation Boards and Commissions have been successfully established throughout the United States is based upon a mutual recognition of a common problem and a willingness

between Boards of Education and Park Departments to cooperate in finding the most efficient way to use the resources of both agencies in a tax-supported program of recreation. For whatever reason, such mutual recognition has not existed with the Board of Recreation in Boston.

In the last two years the School Committee and the Park Commission of Boston have been working more cooperatively in the interest of organizing and directing joint programs of play and recreation than they have in the past. They have made some progress and more progress seems possible.

In view of these facts and recommendations made in other sections of our report, we can see little need for the Board of Recreation in Boston. Mr. Pangburn, who made the original report which led to the establishment of the Board of Recreation and who has been a member of this survey staff, joins in this decision. Therefore —

WE RECOMMEND: (25 in our full Report) Legislation should be enacted replacing the present Boston Park Commission and the Boston Board of Recreation with a Park and Recreation Board of 5 members: the Chairman of the Metropolitan District Commission and the Superintendent of Schools, *ex-officio;* a Chairman of the new Board; and two interested and capable citizens willing to give time and effort to the work of the new Board, appointed in accordance with such legislation.

*The Boston Public Library*

All of the Health and Welfare Areas in Boston are provided with branch libraries under the control of the Library Department of the City. Public Library facilities and services are important to a recreational program serving all ages. The general tendency has been to think of them as separate and apart from other recreational facilities and services, but this tendency should be reversed.

WE RECOMMEND: (26 in our full Report) The Library Department should integrate both its facilities and its services in all Areas with the other phases of recreation service organized and directed in these Areas.

*The Boston Housing Authority*

In recent years, under the auspices of the Boston Housing Authority, 8 large housing projects have been constructed in different sections of Boston. Included in each of these projects are certain play and recreation facilities. In those not located in close proximity to a public playground, small play areas for little children are provided, and three have nursery school rooms in them. All have one or more auditoriums or halls for meetings and some have smaller play and meeting rooms and kitchens for group use.

Under the auspices of the Housing Authority, each of these projects is provided with a recreation leader or leaders to organize and direct a play and recreation program primarily for those living in the project. A great deal of emphasis has been placed on volunteer work by tenants and the organization of tenant committees to sponsor the program. Although reports of the Housing Authority indicate that the tenants of these projects have been urged to use the facilities of tax-supported and voluntary agencies and to participate in their programs, and the general community has been invited to share in the programs of the Housing Projects, there is no way of measuring how much of this has taken place. It is most important, however, that this type of community participation take place; otherwise the projects and their residents tend to become set apart from the rest of the community.

WE RECOMMEND: (27 in our full Report) In the development of cooperative and jointly planned programs of play, recreation and group experience in each Health and Welfare Area, the residents in Housing Projects within each such Area should be deemed residents of the Area, and the programs, as organized and directed by Housing Authority representatives, should become an integral part of the total Area program.

*The Boston City Planning Board*

The Boston City Planning Board is the official planning body for the City of Boston. The 1946 Annual Report of this Board states: — "It is the belief of the Board that the preparation of a sound program for the comprehensive development of recreational facilities for the entire city is of major importance. The Board also believes that the creation of open space or playgrounds in depreciated areas is a vital requisite as the City's contribution in encouraging the rebuilding of these areas."

WE RECOMMEND: (28 in our full Report) The City Planning Board should proceed as rapidly as practicable with the development of a Master Plan of Recreation Facilities for the City of Boston, which should include the use of the properties of voluntary agencies.

In concluding the comments and recommendations pertaining to tax-supported agencies, it must be stated that the most essential requirement is genuine cooperation based upon mutual respect and under-

standing. None of the foregoing recommendations is of real value except as it fits into a total plan of operation as outlined in this report. It is essential, therefore, that officials connected with tax-supported agencies fully recognize that the burden of leadership in this development rests as heavily on their shoulders as it rests on the officers of voluntary agencies. It is only as these two groups willingly come together, as men and women of good will, to plan and act for the common good of the community that desirable and attainable results will be achieved.

*B. Voluntary Agencies*

In considering voluntary agencies in the recreation and group work field, we have been governed by two considerations already stated: *first*, the principle that their purpose is to build against the background and on the floor provided by tax-supported agencies, still retaining their freedom to meet the special needs of individuals and groups; *second*, the underlying principle of the Survey: "to make sure that the charitable dollar annually raised in Greater Boston does the greatest good for the greatest number in the most economical, effective way." The discussions and recommendations that follow set forth some of the action we regard as necessary to these ends.

Our discussions in this Summary Report are necessarily and unavoidably brief. The reader to whom they may seem curt and not maturely considered, is referred to our full Report, — and to the supporting basic studies, — where pages are devoted to what is treated here in a few sentences.

We first present our recommendations as to major agencies with a community-wide aspect.

*Community Recreation Service, Inc.*

We recognize the excellent pioneering contribution of Community Recreation Service to the development of play and recreation in Boston and the area surrounding it. Great advances have been made, however, since its establishment in 1919. The Greater Boston Community Council is undertaking, in a broader and more inclusive way, the promotional and planning function which was one of the two major reasons for establishing Community Recreation Service. The second major reason for its establishment was to conduct various recreation services on a demonstration basis. We have analyzed its present activities falling under this second heading. While impressed with their variety, we do not see that in 1949, with all that is being done by all the other agencies carrying on specialized recreation and group work programs, that such activities now represent, or similar activities will in the future represent, *demonstrations* so vital as to justify the maintenance of a separate agency. Therefore:

WE RECOMMEND that Community Recreation Service Inc. should plan to cease to operate as an independent agency; and should follow the detailed recommendations for the re-assignment of its present activities and assets which we outline in Recommendation 29 of our full Report of the Recreation and Group Work Division.

*Boston Music School; South End Music School*

These schools are specialized training institutions in musical education, with an avocational emphasis that has been deemed to qualify them as social agencies. We do not think they should any longer be so qualified. Each has a differential fee-charging policy, but the intake policy of neither is sufficient to enable it to determine those pupils who can rightly be expected to pay all the cost of their instruction or the percentage of such cost which other pupils may rightly be expected to pay. Both schools are well-filled.

WE RECOMMEND that a plan should be developed to place the Boston Music School and the South End Music School on a self-supporting basis, including their possible consolidation; we suggest careful restrictions on future Community Fund allotments, if any, to make sure that such allotments will be used *only* for purposes that clearly serve a welfare purpose as the term "welfare" is normally understood; and we suggest ways to use nearby public school facilities that will increase the effectiveness of the music schools. (Recommendation 30, full Report.)

*The All Newton Music School*

At the time of our field work, 65 pupils (approximately 10 percent of the enrollment) comprised what may be called the School's social service clientele. This group paid fees ranging from nothing to something less than $2.00 an hour for individual lessons; fifteen percent of the pupils paid $2.50 an hour; and the balance paid $2.00 per hour. Two dollars and forty-seven cents per hour covers all costs.

The heavily subsidized enrollment represents so small a proportion of the total (10%) and the remaining 90 percent come from families able to pay so large a part of the cost of instruction, that we think the school can be put on an independent basis, without support from the Community Fund. Pupils unable

to pay $2.50 an hour could be absorbed in the public school music program or be taken care of by scholarships arranged by the management of the School.

We Recommend that the school be placed on a self-supporting basis, all Community Fund allotments to be terminated at an early date. (Recommendation 31, full Report.)

*The Children's Museum*

The Children's Museum is an educational and recreational agency offering widespread service throughout Greater Boston. The major portion of its service is rendered to public school children. Its financial support should stand on the same basis as the public schools, the Public Library, the public parks; none of which depend on the Community Fund for operating expense. The Museum's facilities and services are an important part of the floor of facilities and services which should be provided through tax-supported agencies. Interested private sources may wish to make gifts direct to the Children's Museum.

We Recommend that the Community Fund make no allotments to the Children's Museum for periods after this year, and that thereafter it be financed to the extent needed through tax funds or private gifts. (Recommendation 32, full Report.)

*International Institute of Boston, Inc.*

The International Institute is a multiple-function agency, doing both casework and group work with persons whose "foreign-ness" constitutes a barrier to their successful adjustment to life in Boston. Its group work consists of conducting a number of clubs for persons of differing nationality backgrounds. We do not see the need for a special agency for this purpose. We think it far better practice and more tending toward American unity to involve these groups in club programs in the neighborhoods or districts in which they live. The neighborhood and district agencies should accept this responsibility.

We Recommend the discontinuance of the present recreation and group work program of the International Institute; and the development of a new program designed to aid persons handicapped by their "foreign-ness" to become affiliated with recreation and group work programs in the areas in which they live. (Recommendation 33, full Report.)

*Wells Memorial Association*

The Wells Memorial Association operates a small educational and recreational center in an old building in the downtown section of Boston. Because of this building's poor condition, it cannot much longer be used with safety. Its program is of such a nature as to lend itself to easy consolidation with other agencies with generally similar purposes and program opportunities.

We Recommend that the Wells Memorial Association be consolidated as promptly as possible with the Boston Young Men's Christian Union (itself to be reconstituted under a later recommendation); and in our full Report we add certain provisions insuring a continuance of the purposes and the name of Wells Memorial Association within the YMCU program, continuance of Community Fund allotments for the support of such purposes, and transfer of the capital funds of Wells Memorial Association to the YMCU to the same end. (Recommendation 34, full Report.)

*The Young Men's Christian Association; the Young Women's Christian Association; the Young Men's Christian Union*

Our full discussion of the activities of these agencies is too long even to be summariezd here. We refer to the quality of their service; note their similarities and differences; and indicate the respects in which their work seems to us a little out of balance. We have made recommendations designed to redress this balance — e.g., in the matter of a better distribution of age groups among those served. We endorse the cooperative work of the YMCA and YWCA at Greenwood Youth Center, and urge the promotion and expansion of this kind of development in cooperation with other agencies. We recommend more intensive central planning by the YMCA's and the YWCA's, "not only in regard to building plans and program modification and extension, but also for the regular sharing of common problems and for mutual reinforcements". Our Recommendation 35 (full Report) — and Recommendation 36 (full Report) dealing with the YWCA is similar — reads:

"Recommendation 35 (a): The Boston YMCA, through its several branches, should join with other agencies in the cooperative development of a comprehensive play, recreation, and group experience program in each Health and Welfare Area. Such program should include the use of the facilities operated by tax-supported agencies in each such Area.

(b) The suburban YMCA's should undertake similar action in the respective areas which they serve."

Our most significant recommendation affecting these agencies, however, has to do with the development of a Down-Town Community Center under a Board of Directors representative of all their interests and of those of the Burroughs Newsboys Foundation (which agency, as will appear below, we think should be consolidated with the YMCA). We quote from our full Report:

"The YMCU is operating in a building which is excellently located to give service to the downtown section of the City. The building, however, is old and not worth the expense of remodelling and repair to make it a modern building meeting the needs of this area.

"The YMCA has no downtown location to give service to its constituents in this area. It is operating a Chinese Branch at the edge of the area which is of doubtful value due largely to inadequate facilities.

"The Berkeley Street Residence of the YWCA, a residence for employed women, is old and past repair. Plans for a new building to replace this building have been considered and approval has been requested for a capital fund drive to raise $1,000,000 for this purpose.

"The last war has taught the value of cooperative service between national agencies and demonstrated the desirability and practicability of several of these agencies working cooperatively in one central facility. . . . These agencies are now confronted with an opportunity to symbolize the unity in service for which the war-torn world waits, and thus make history."

Our recommendation for setting up a jointly operated Down-Town Community Center is as follows:

"(a) The present YMCU building should be replaced by a new building functionally designed to serve as a Down-Town Community Center, to be located at or near the present site of the YMCU, and should be equipped to carry on, under united auspices, a varied program of education, recreation, and group experience for all ages and both sexes, and, at the same time, to provide in a separate wing of the building modern rooming accommodations for young women to replace the present Berkeley Street Residence of the YWCA.

(b) The control of this operation should be vested in a new Board of Directors, to be representative of the interests of the YMCU, the Wells Memorial Association (see Recommendation 34, full Report), the YMCA, the YWCA, and the Burroughs Newsboys Foundation (see Recommendation 59, full Report), and at least three citizens not now connected with any of these agencies.

(c) Appropriate provision should be made for the use of the financial resources of the agencies involved in the construction and operation of this new Community Center.

(d) When this new Community Center becomes available, the Chinese Branch of the YMCA and the Berkeley Street Residence of the YWCA should be discontinued." (Recommendation 38, full Report.)

In addition, we urge that effort be directed to have the Boston Park Commission develop a portion of that part of the Boston Common, set aside for active play and sports, into an activity area to be made available as an outdoor sports and games area for the members of this Down-Town Community Center.

Such a Down-Town Community Center, with a building housing a rich and varied program and with a sports and activity area readily accessible thereto, would be a real contribution to the recreational needs of Boston and would represent an efficient, economical unit for cooperative effort on the part of the agencies concerned.

*The Catholic Youth Organization*

The primary purpose of the C. Y. O. program is to enrich and deepen the spiritual life of boys and girls, young men and young women, and to advance their temporal interests. It strengthens and develops existing Catholic organizations in every parish. It supplements, but does not supplant, other desirable and wholesome activities. The parish is the basic unit, and hence organization emphasis is placed upon each parish pastor. In this way, the program is neighborhood-centered, even though the Archdiocese maintains a central organization to promote and strengthen the program in each parish. The usual program directors are a cultural director, an athletic director, and a social director.

The C. Y. O. program in the Greater Boston Area is growing rapidly. At the time of our field study, it had a membership of 31,556 in Greater Boston. In Municipal Boston there are 38 parishes with active C. Y. O. programs, located in every Health and Welfare Area (except North End and West End). A program of such purpose and scope is a most important part of the community's program of play, recreation and group experience, and should be so considered in any effort to plan for a coordinated, community-wide program of these services. However, in its growth to date, the Catholic Youth Organization programs

have been largely developed independently of consideration of other agency programs, with the exception of the program of the Department of Extended Use of Public Schools. Between these two programs considerable cooperative planning exists.

We Recommend: That the C. Y. O. should cooperate in jointly planned programs with all agencies operating in each Health and Welfare Area, and that C. Y. O. representatives should become active participants therein. (Recommendation 40, full Report.)

*Associated Jewish Philanthropies: Group Work Services*

This organization is a federation of YMHA's, YWHA's, and Jewish Community Centers and is active throughout the Greater Boston Area. The agencies included in the federation are also affiliated with the New England Section of the Jewish Welfare Board, which follows the policy of having its affiliates serve as community organizations with programs serving all groups and both sexes. They are in essence neighborhood organizations. Particularly in those Health and Welfare Areas of Boston and the communities in the Greater Boston Area with a large percentage of Jewish population, the programs directed by the agencies affiliated with the Jewish Welfare Board are important parts of the total community program and should be so considered.

We Recommend: That the federated Jewish group work agencies should participate in the development of a jointly planned and coordinated program of play, recreation, and group experience in each Health and Welfare Area and in each community in which they are operating. (Recommendation 41, full Report.)

*Miscellaneous Agencies with Community-wide Aspects*

In several of the small communities in the Greater Boston Area, small but effective agencies organize and direct some phase of their communities' program of play, recreation and group experience — viz., Dedham Community Association, Cohasset Community Center, Cunningham Foundation (Milton), Davis Bates Clapp Memorial Association (Weymouth), Canton Youth Committee, and the Wayland Junior Town House. Such agencies are important and their programs should be considered and planned as integral parts of the total programs of the respective communities.

The Dedham Community Association operates a Community House, — a large, old residence used throughout the year for recreation and community activities, — and a large playground and play field; located in a large park-like area in the center of Dedham. In summer it operates a swimming beach on the Charles River. When founded in 1922, the Association was the only recreation agency of consequence in Dedham; hence it was necessary for it to provide the total program of play, recreation and community activities, including a floor of facilities. The Town of Dedham now has a Recreation Committee with a Director of Recreation. This Committee operates 5 summer playgrounds and a swimming beach. Such extensive facilities as those of the Association are generally provided and maintained out of tax funds. Voluntary funds should not be used indefinitely to support this type of facility.

We Recommend: that the appropriate Division of the Greater Boston Community Council, in cooperation with the Dedham Community Association, the Town officials, and the Recreation Committee, should develop a plan to transfer to the Town of Dedham the property of the Dedham Community Association for operation as a tax-supported community and recreation center. (Recommendation 42, full Report).

We now take up our recommendations as to major agencies with neighborhood aspects.

Chief among such agencies are Neighborhood Houses and Settlements, Boys' Clubs, Girls' Clubs, and in Boston the Children's Art Centre and the Neighborhood Department of the Children's Aid Association. We present first our general conclusions regarding Neighborhood Houses and Settlements. These conclusions are of two sorts:— conclusions as to the proper and most effective role such agencies can play in a community program of play, recreation and group experience, and conclusions as to the organization and administration of such agencies in specific areas in the City.

*The Proper Role of Neighborhood Houses and Settlements*

A settlement, in its original concept, was a group of people residing in a poorer district of a city for the purpose of learning district needs and resources at first hand, helping to meet them, and interpreting them to the general public.[1] In this country, during the period of heavy immigration of non-English speaking people, Settlements became primarily concerned with understanding and interpreting

[1]Grace Abbott, *A Survey of Boston Settlements and Neighborhood Houses*, 1934, p. 3.

the needs and problems of such people as they established their homes in the district served by the Settlement. Strictly speaking, a Settlement was not a Settlement unless it had a group of people resident in the building who were available at any hour to respond to emergency calls for assistance. Neighborhood Houses conceived of their function as similar to Settlements, except that they tended to maintain no residential group.

Immigrants no longer come in a steady stream and settle in neighborhoods almost of their own making. Population is mobile and is constantly shifting in keeping with changes in industrial development. Its horizons are broader; hence its pattern of living no longer tends to be restricted by neighborhood boundaries or associations. The net result of this is that many Settlements and Neighborhood Houses find themselves periodically confronted with a new population whose entire life is of a different pattern from the pattern of those whom the agencies were originally established to serve.

Settlements were not presumed to carry on institutionalized programs, but rather were to be free for experimentation and quick responses to changing conditions and needs.[2]

Working on a neighborhood basis, Settlements and Neighborhood Houses come in contact with a variety of neighborhood needs. Their tendency has been to attempt to meet these needs by assuming a variety of program functions in *all* the fields of social endeavor, which today are classified as group work, casework, public health, nursery care, playgrounds and recreation, etc. As time has elapsed and more and more of these functions have been accepted as community functions, separate specialized agencies have been established to fulfill them. Slowly, sometimes reluctantly, Settlements and Neighborhood Houses have recognized the changes that have taken place, and have changed their programs accordingly. To a large extent, however, they are today centers for play, recreation and group work for children and young people. Experimentation, an original primary purpose, appears to have dropped off in almost direct proportion to the increase in fixed programs. The same appears to be true of neighborhood visitation by the staff. Also, their buildings, which were originally to be of residential character, have been expanded to include gymnasiums, auditoriums, shops, class and craft rooms and meeting rooms of many types, and it is not unusual to find them with their own playgrounds and camps.

The Settlements and Neighborhood Houses of Greater Boston have generally followed this pattern of development until today they are primarily centers for play, recreation and group experience for the children and young people in the neighborhood in which they are located. They have largely divorced themselves from program functions which they have pioneered and demonstrated, and which have come to be accepted as functions of specialized agencies. We think they should relinquish these more recently acquired activities and return to a kind of program more like that of their earlier days, adapted to modern conditions.

Local circumstances control to some extent the activities these agencies should discontinue. There is little question, however, about some activities. Certainly library service for the public, in connection with Neighborhood Houses and Settlements in the Greater Boston Area, should no longer be financed by voluntary contributions: although, of course, informal reading rooms are necessary and acceptable. Similarly, provision of casework service, nursing service, and clinics should no longer be supported out of the funds of Neighborhood Houses and Settlements.

Many of the Neighborhood Houses and Settlements in Boston are now operating nursery schools or day-care centers for small children. These programs, if properly conducted, require adequate rooms and space with proper heat, light and ventilation. They are specialized programs for children whose age range is now accepted as of the utmost importance in their emotional and personality development. Accordingly, day-care centers require people in charge of them who have specialized training for such work. The time may come when these programs, like the kindergarten programs of the past, will be accepted as a part of the regular public school program. In the meantime, it is exceedingly difficult for a multiplicity of Neighborhood Houses and Settlements, with their old buildings and inadequate budgets, each to house and conduct such programs properly. Some better and centralized arrangement should be made to carry forward these pograms, which are important in many parts of the City. There should be provided a uniform and more economical administration than can be possible under the existing diffusion of this service among over a score of different agencies.

We submit specific recommendations on all these matters. In the case of day-care centers, our specialists in the group work field agree with our specialists in the casework field, and propose the formation of a new Day Care Association which should become responsible for organizing and operating day-care centers, under suitable restrictions, in the parts of the City where such centers are needed. These restrictions are carefully set forth in our full Report (Recommendation 44). On all

[2]Abbott, op. cit.

points, our specialists in the group work field endorse the findings and proposals detailed in our Voluntary Casework Division Report — Day Care Services for Young Children.

We speak also about the traditional practice of Settlements in maintaining living quarters for staff engaged in the Settlement program. The original policy was particularly applicable to headworkers, as they represented the very core of the Settlement program. Many Boston Settlements no longer adhere to this policy; their residential quarters are largely used by students who work on a part-time basis in the Settlement program. The value of the latter practice is open to question, because the identification of such part-time workers with the program of the Settlement is limited in time. We recommend the discontinuance of this practice, except where the headworker or a full-time member of the staff has maintained residence over a period of years or where a clear financial advantage to the Settlement is demonstrable (Recommendation 45, full Report).

Direct service to people living in the area served by Neighborhood Houses and Settlements is a traditional function of these agencies. As both tax-supported and specialized voluntary agencies are established to carry certain functions which may have become a part of Neighborhood House and Settlement programs, care must be exercised to see that the necessary adjustments are made in such programs, shifting to the new agencies their proper responsibilities. *Basically, Neighborhood Houses and Settlements should be interpretation and referral centers for all such specialized agencies and for the people residing in the area in which they are located. In addition, they should be sources of general information about community resources, the proper channels to use in securing help on all kinds of problems, service to indigenous groups from gangs to citizens' associations, etc. Service to people, therefore, should still remain the basic function of these agencies.*

Historically, these agencies have served small geographic areas and have been primarily concerned with the development of neighborliness and understanding among the people residing in these areas. The need for neighborliness and understanding among people today is as great as it has ever been. But boundaries mean less, horizons are broader, and interests tend to be not merely community-wide but world-wide. It is essential, therefore, that neighborliness and understanding be developed accordingly, as all people share in the responsibility for conditions in the wider community.

In projecting a role for the Neighborhood Houses and Settlements in the Greater Boston Area, which is in keeping with the wider community idea, these agencies should think in terms of providing their service to larger geographic areas. *In Municipal Boston the Health and Welfare Areas are the geographic areas with which they should properly concern themselves.*

American cities today are in great need of a dynamic program directed toward their improvement and a better understanding by the people generally of the complex problems to be solved if these cities are to move steadily forward along the road of sound progress. Boston is certainly no exception. An agency in each Health and Welfare Area of the city which accepts as one of its primary functions the organization and direction of such a program would be well worth its cost. It must be well planned, thoroughly organized, and ably directed. It must be comprehensive in scope, bringing together representatives of the various forces in the community for fair and honest discussion of community requirements and problems. It must be a program for adult participation and geared to the understanding of the people. Neighborhood Houses and Settlements are admirably suited to develop such a program.

In further elucidation of this change from the prevailing current role of Neighborhood Houses and Settlements, our full Report contains a great many concrete suggestions and several additional recommendations. Those for whom the subject has special interest will wish to read that Report with care. The additional recommendations, quoted below, will convey an idea of our views that is sufficient for this Summary Report:

"*Recommendation 46:* Each Neighborhood House and Settlement should consider as one of its primary responsibilities in program development for the Area in which it is located, the organization and direction, in cooperation with all agencies in such Area and as a part of the Community Center program of each School Center, of an adult discussion program to focus upon vital civic responsibilities and problems.

"*Recommendation 47:* Each Neighborhood House and Settlement should join forces with all agencies, tax-supported and voluntary, operating in the Area in which it is located, and give leadership to the development and operation of a seasonal playground, play fields and Community Center program for such Area. This program should be based upon the following:

(a) The basic purpose should be to use the total resources available in the Area, efficiently and economically.

(b) In so far as is now practicable, the tax-supported agencies should provide all playground and play field service. These agencies should be urged and aided to secure the necessary appropriations for this purpose.

(c) Tax-supported gymnasiums should be used for the athletic and sports program of the Area and at least one such gymnasium in each Area should be set aside as an Athletic Center for this purpose and its use regularly scheduled.

(d) All efforts should be focused on developing, in each School Center in the Area, a complete Community Center program organized and directed to provide a broad program of recreation and group experience opportunities for youth and adults, including the aged. Programs appealing to the family as a unit should also be a part of this Community Center program.

(e) The staff of the voluntary agencies should be used in the operation of these programs.

(f) The facilities of the Neighborhood Houses and Settlements should thus be made available for informal use.

"*Recommendation 48:* Neighborhood Houses and Settlements should hold in abeyance any plans for remodelling, new construction or removal to different buildings, until such time as a Master Plan of Play, Recreation and Group Experience Facilities has been developed for the City (See Recommendation 28, full Report).

"*Recommendation 49:* Neighborhood Houses and Settlements, in keeping with the transition from a program of activities to a program of community education, as recommended in this Report, should seek headworkers and staff qualified to conduct the new program, and should develop up-to-date codes of personnel practices.

"*Recommendation 50:* Each Neighborhood House or Settlement should accept as one of its responsibilities the provision of opportunities for adult citizens resident in the Area in which the agency is located, to participate in policy-making discussions affecting the program in such Area. These opportunities should be provided either through membership on the Board of the Neighborhood House or Settlement; or through service on such agency's Advisory Committee."

The foregoing recommendations bearing on Neighborhood Houses and Settlements set forth a program which, in its orderly carrying out, will largely divest them of responsibility for the operation of large buildings, including living quarters for staff; for the operation of libraries and clinics and the provision of casework and nursing services; and for the operation of nursery schools and day-care centers. These recommendations chart the outline of this new program on the basis of serving larger geographic areas, such as the Health and Welfare Areas in Boston. In these Areas, Neighborhood Houses and Settlements become agents of coordination for programs of play, recreation and group experience for children and youth; organizers of an adult discussion program centered on civic responsibilities and problems as a part of the Community Center program to be conducted in School Centers; providers of opportunities for citizen participation in the development of programs in the Areas; and sources of information and referral to the people residing in the Area in which they are located. They employ an activities staff, to aid in programs of play, recreation and group experience for children and youth, until such activities can be fully carried by the proper agencies. This transition by Neighborhood Houses and Settlements to the proposed new role must be one of slow evolution. Changes in conditions may doubtless call for some changes in the steps recommended.

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*The Executive Committee of the Survey dissents in part from the new role proposed by the Staff for Neighborhood Houses and Settlements, for the following reasons (including in such partial dissent specific clarification of the Survey's position as to various other recreation and group work agencies):*

*"1. The Executive Committee is deeply concerned with the number, location, character of services, and annual expenditures of the recreational and group work agencies in Boston. Without delay, action should be taken in general conformity with the Survey recommendations as to Settlement and Neighborhood houses, as modified by this statement. Plans for such future action should be cooperatively developed in conferences by representatives of the affected agencies, acting under the auspices of the appropriate Division of the Greater Boston Community Council; and such joint plans should be carried into effect in 1949 to the maximum extent possible.*

*"2. The Executive Committee supports certain basic principles set forth in the Recreation and Group Work Division Report:*

*"a. Settlement and Neighborhood Houses in each Health and Welfare Area should be merged and consolidated. (Recommendations No. 51, No. 52 (as modified), No. 53, No. 54, and No. 55,*

*full Report.) Such integration should produce fewer and stronger units capable of more effective planning and service, eliminate duplication and overlapping, result in economies.*

*"b. Settlement and Neighborhood Houses, and other agencies, should transfer their day-care programs to a Day Care Organization. (Recommendation No. 44, full Report. See Day Care Services for Children, Voluntary Casework Division Report.)*

*"c. Settlement and Neighborhood Houses, Boys' Clubs, and Girls' Clubs, should discontinue the operation of extensive libraries, clinics, casework and nursing service, referring persons to the proper tax-supported or specialized agencies. (Recommendations Nos. 43, 58, 60, full Report.) An agency is not entitled to general public support through the Community Fund for services which overlap or duplicate, on the ground of convenience.*

*"d. Settlement houses should restrict the 'living in' of staff in conformity with Recommendation No. 45, full Report.*

*"e. Settlement and Neighborhood Houses should not remodel existing facilities, build new facilities, or remove to different buildings, except as necessary to carry out the Survey Recommendations. (Recommendation 48, full Report.)*

*"3. Should a Settlement House concentrate in its small 'neighborhood' or diffuse through a 'Health and Welfare Area' embracing several 'neighborhoods'? It is manifestly not an economic possibility to establish and operate out of voluntary funds a Settlement House in each of the 63 'neighborhoods' recognized in Boston proper. The Executive Committee believes in moving from concentration toward diffusion, from 'some' people to 'more' people. Accordingly, there must be maximum utilization of tax-supported facilities, provided at great expenditure of public moneys, so as to spread the Settlement-Neighborhood programs more widely than is possible through use merely of facilities provided by voluntary funds.*

*"4. The 'new role of the Settlement and Neighborhood Houses', as outlined in the Recreation and Group Work Division Report (especially pages 123-129), is a long-range objective. The Executive Committee believes such role to be a worthy objective towards which to move. Obviously progress can be made more rapidly in some areas of the City than in others.*

*The Executive Committee does not, however, agree that Settlement and Neighborhood Houses should now or in the foreseeable future altogether shed their activities programs. It believes that certain activities programs are a potent medium for reaching families, attracting volunteers, and improving community standards, and have in and of themselves positive value which should not be sacrificed.*

*"5. The Executive Committee desires explicitly to clarify the Survey's position as to the Catholic Youth Organization, the Jewish agencies, the Boys' Clubs, the Girls' Clubs, the YMCA, the YWCA, and the YMCU in the recreation and group work field. These agencies should continue their respective operations as integral parts of the total program offered to the citizens of Greater Boston, in each Health and Welfare Area and on a community-wide basis. There is no proposal to give leadership or control to any one voluntary agency in the recreation and group work field. The prudent proposal to make wider use of the tax-supported facilities does not imply or favor control by the taxing power, except in the traditional areas of schools, libraries, museums, parks, playgrounds, etc.*

*"But the Executive Committee strongly believes that each of the above-mentioned agencies has a responsibility to bear its fair share in working out sound plans for the benefit of everyone in the community and in carrying such plans into effect. When the public at large is asked to contribute to the support of voluntary agencies, it is entitled to have the cooperation and best judgment of all the agencies working within a given field. In a non-sectarian, non-partisan spirit and as equals, people of goodwill from all agencies should be glad to sit down together and work through the Community Council for the attainment of this objective."*

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*Neighborhood Houses and Settlements in Specific Areas of Boston*

In addition to considering the most effective role for Neighborhood Houses and Settlements in a community program, we considered also the way in which they are now organized and administered in selected areas of Boston: South End, North End, West End, East Boston, Roxbury, Dorchester, Brighton, Jamaica Plain, and South Boston.

Once again, for a complete statement of our findings and recommendations, our full Report must be consulted. Here it can be said that the general pattern of Neighborhood Houses and Settlements in the above named areas is marked by: concentration of similar facilities in relatively small areas of the City; independent and costly overhead; too many buildings, too old and ill adapted to the kind of

program we propose for such agencies; too great a desire on the part of each agency to have its own plant as self-contained as possible: too little use of tax-supported buildings and equipment which we are convinced can be made available; prevailing emphasis on activities that appeal to children and young people. To render equal service by voluntary agencies to all persons in Boston between the ages of seven and sixteen, who can be assumed to need it equally, would be flatly impossible on grounds of cost. The existing concentration of Neighborhood Houses and Settlements in certain local areas, serving a limited group of persons, results in a denial of service to persons whose need is equal but who are forced to go without because of the geographical accident that they live elsewhere. To explain this situation historically is not to defend it rationally. It falls short of the principle that the charitable dollar should do the greatest good for the greatest number in the most economical, effective way.

We recommend a fundamental reorganization of the agencies in these areas so that the money spent on them may go much farther and serve more people. Our recommendation for the South End area will be given in full, for the purposes of illustrating a procedure we believe should apply in each Health and Welfare Area:

"*Recommendation 51:* The appropriate Division of the Greater Boston Community Council, with representatives of Lincoln House, Hale House, South End House, Ellis Memorial, Harriet Tubman House, and the Children's Art Centre, should develop a plan to effect the merger and consolidation of these six agencies in accordance with the following:

(a) A qualified headworker should be employed as the headworker for the consolidated agency.

(b) A single Board representing all interests should be organized as the Board for the consolidated agency.

(c) The financial resources of all the affected agencies should be consolidated in so far as is possible. Their funds should be used for the work of the consolidated operations and legal action to this end should be sought if necessary. The Community Fund allotment for the consolidated operation should be reduced to conform to the total plan of this Recommendation, one aspect of which is the suggested salary budget in Table 10 of the full Report.

(d) A qualified staff should be selected in accordance with the general plan in Table 10 of the full Report and employed as rapidly as possible.

(e) The appropriate Division of the Greater Boston Community Council should, in cooperation with representatives of the consolidated agency and of other voluntary and tax-supported agencies operating in the South End, plan a complete program for the Area in accordance with the recommendations of this report. (See pp. 121-130 of our full Report, especially Recommendation 47, p. 126.)

(f) The buildings now operated by the affected agencies should be objectively appraised with respect to their present and potential use. Those buildings determined to be without value to the over-all program should be disposed of.

(g) The Children's Art Centre should be used as an Area Center for a program of recreational art, which forms an integral part of the total Area program."

Equally fundamental are the recommendations we make for Neighborhood Houses and Settlements in the North End and the West End. The chief such agencies in the North End are North End Union and North Bennet Street Industrial School (a combined settlement and trade school); in the West End, Elizabeth Peabody House and West End House (a non-Fund agency). We recommend treating the two Areas as one; joint planning for the consolidation of all settlement functions in the manner recommended for the South End, with North Bennet Street Industrial School giving up its settlement program; and developing qualified staff and a complete program for the combined Areas. In view of the trade school opportunities provided in the public schools, we think support of a private trade school in Boston is not a responsibility of the Community Fund, however effective the program of such school may be: and we recommend early discontinuance of Fund support of the trade school activities of North Bennet Street Industrial School.

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*The Executive Committee of the Survey dissents in part from the Staff Recommendation (No. 52, full Report) in regard to the North End and West End and in regard to North Bennet Street Industrial School, for the following reasons:*

*"1. a. The Executive Committee supports the basic principle that Settlement and Neighborhood Houses in each Health and Welfare Area should be merged and consolidated, as outlined in Recommendations No. 51 (South End), No. 53 (East Boston), No. 54 (Roxbury), and No. 55 (Dorchester).*

*b. Recommendation No. 52, however, suggests the development of a plan for merging and consolidating into one agency certain Settlement and Neighborhood Houses located in two Health and Welfare Areas (the North and West Ends). Despite the relatively small geographical size and the contiguity of these two Areas and certain population similarities, the Executive Committee does not believe that combined operations for the North and West Ends should be attempted or could reasonably be expected to succeed. Therefore, it believes that integrations conforming to the basic principle should be respectively carried on in each said Area.*

*"2. With reference to North Bennet Street Industrial School, the Executive Committee agrees that its trade school activities should not be financed by voluntary charitable contributions raised from the public at large, but dissents from the recommendation that its settlement program be discontinued. To the contrary, the Executive Committee believes that North Bennet Street Industrial School should continue that program, but in conformity with the Executive Committee's views on the 'new role of Settlement and Neighborhood Houses' (as set forth in its preceding partial dissent). As stated above, North Bennet Street Industrial School should seek to integrate with other like agencies in the North End conformably with the basic principle above referred to."*

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Our full Report proceeds to consider, in like manner and subject to the same principles, the consolidation and merger of agencies in the other areas of Boston or some modification of their existing status and operations:

*In East Boston* (Rec. No. 53)
Trinity Neighborhood House
Good Will Neighborhood House
East Boston Social Centers Council

*In Roxbury* (Rec. No. 54)
Robert Gould Shaw House
Roxbury Neighborhood House
Norfolk House Centre

*In Dorchester* (Rec. No. 55)
Denison House
Dorchester House
Little House
Greenwood Youth Center

*In Brighton* (Rec. No. 56)
Gray Houses, Inc.

*In Jamaica Plain* (Rec. No. 56)
Jamaica Plain Neighborhood House

*In South Boston* (Rec. No. 57)
Olivia James House

Not even for a recapitulation of our discussion or our recommendations on all these agencies and Areas, is there room in this Summary Report. Those for whom the subject has special interest will in any event read the full Report. The essential result at which we aim in all Areas is the same: wherever possible, planning under Council auspices for consolidation of like agencies within an Area; recruitment of qualified staff; joint planning between voluntary agencies and tax-supported agencies, again under Council auspices, for a complete program for the Area in accordance with earlier recommendations; discontinuance of use of unsuitable buildings and outmoded programs; merger or elimination of agencies too small or not properly located for effective work; maximum use of appropriate public facilities; strengthening of good program activities now inadequately supported; — all to the end of cutting down overhead and serving more people with less duplication of effort and at a lower cost per person served.

*Boys' Clubs*

Boys' Clubs, though not as numerous in Greater Boston as some other kinds of agencies, are important factors in the total agency pattern. Because of a somewhat rigid philosophy and pattern of building operation, they seem to find it difficult to participate in a coordinated community program in the areas in which their buildings are located. Even recognizing the validity of their restricted building program, they should participate in over-all community planning.

The basic philosophy of the National Boys' Club organization is that a Boys' Club is more than a club; it is a boys' guidance organization. In keeping therewith, the Boys' Clubs of Boston (with clubhouses in Charlestown, South Boston, and Roxbury) is complete and institutionalized. It organizes and directs a program of physical activities, including the operation of swimming pools, playground programs, classes in typewriting, woodworking, printing, model airplanes, cooking, photography, radio

and electricity, automobiles, and handicraft. It conducts social and special activities of many kinds, maintains a library, a game room, and rather complete health and dental clinics.

The support of institutionalized buildings for such activities, largely for the benefit of boys of school age, is an expensive way to provide this program. When it is considered that these activities largely take place after school hours, on Saturdays, and in vacation periods, when School buildings are not in use, the question logically arises — couldn't public school buildings be used for this purpose? They are geographically located to serve definite areas, have usable facilities, and should be available. The average cost of conducting activities two days a week during the school year in 14 School Centers, now being operated in Boston, was approximately $4,185 per School Center per school year of 9 months. This method of approach obviously provides a great number of opportunities for boys to participate in programs of this type. The average cost of conducting activities 6 days a week during the whole calendar year in the 3 Boys' Club centers was approximately $74,560 per Boys' Club Center per year.

We Recommend: (a) The Boys' Clubs of Boston should actively participate and cooperate with the appropriate Division of the Greater Boston Community Council in planning a coordinated program of community-wide play, recreation and group experience.

(b) Each local Boys' Club should participate fully in the development of the coordinated program of play, recreation, and group experience in the Area in which it is located; and each such Boys' Club should be aided in its local work by a committee of representative citizens resident in such Area.

(c) All Boys' Clubs should objectively appraise their programs and restrict their program expenditures to those parts of their programs which are not a duplication of tax-supported or specialized agency programs. The maintenance of extensive libraries, clinics, and formal educational classes should be eliminated. (Recommendation 58, full Report.)

*Burroughs Newsboys' Foundation*

This agency operates a Boys' Club, primarily for the use of newsboys and boys engaged in the street trades of Boston. It also directs an extension program in certain sections of the city, utilizing neighborhood facilities one or two nights a week, and operates a camp at Agassiz Village. Its three-story building, located at 10 Somerset Street, is a valuable piece of downtown property. The membership of the agency was reported on June 1, 1948, as 2,431, of which 902 were included in the extension program. A daily attendance at the Clubhouse of approximately 200 is reported. The age range of members is from 8-16. The program is a typical program for this age group, with gymnasium classes, arts and crafts classes, social and special activities. Also in operation is a medical and dental clinic. The agency is completely dependent on Community Fund support ($66,985 in 1947). The continued operation of this building for a membership of 1,500 boys, exclusive of those in the extension program, with a total daily attendance of 200, does not seem a justifiable charge upon voluntary giving.

We Recommend: Merger and consolidation of the Burroughs Newsboys' Foundation with the Boston YMCA as an integral part of its Boys' Work program, to be known as the Burroughs Boys' Center; suitable Board direction drawn from both agencies; transfer of the program as soon as practicable to the Down-Town Community Center previously proposed; disposal as soon as practicable of the Burroughs Newsboys' Foundation building. The Foundation's Camp at Agassiz Village may be continued. (Recommendation No. 59, full Report.)

*Girls' Clubs of Boston*

This agency is affiliated with the Boys' Clubs of Boston and in some ways is a joint operation. Although there is great need in Boston for an expanded program of play, recreation and group experience for girls, it should not be necessary to increase the number of organizations, exclusively for this purpose. The same general arguments hold for girls' programs as for boys' programs. Our recommendations for the Girls' Clubs are identical with those above-quoted for the Boys' Clubs. (Recommendation No. 60, full Report.)

*The Children's Aid Association*

This agency is primarily a casework agency. As a minor activity, it operates a Neighborhood Club Department to do specialized *group* work with children who because of their physical condition or certain behavior patterns are deemed to be in need of special guidance and leadership in a group activity program. Children are referred from a variety of sources, such as casework agencies, guidance clinics, hospitals, etc.

More and more, the public schools have been accepting responsibility for doing personal work with children and young people in order better to equip them to take their place in society as normally adjusted individuals. The program of the Neighborhood Club Department fits into a general program of this type. The Boston Public Schools, however, are not now engaged in any extensive program of this kind. If it is properly carried forward for all children who are in need of it, the program must be quite extensive, and, because of its individual approach and the almost certain pressure to expand it, it is expensive. The fundamental question this program raises, therefore, is whether or not the community should be expected to support it by voluntary gifts. If the program is to be continued as a phase of a specialized group work program, it should be the responsibility of a group work agency.

We Recommend: The appropriate Division of the Greater Boston Community Council should explore with the Public School authorities the acceptance by the Public Schools of responsibility for work done by the Neighborhood Club Department of the Children's Aid Association, thus terminating further allotments by the Community Fund for this purpose. If such acceptance is impossible, the Council should decide whether the program is a justifiable burden on voluntary contributors. If the program is to be continued on the basis of voluntary support, it should become a part of the program of a group work agency. (Recommendation No. 61, full Report.)

*Boy Scouts, Girl Scouts, and Camp Fire Girls*

The Boy Scouts, Girl Scouts, and Camp Fire Girls provide the most widespread service of all voluntary agencies in the Greater Boston Area. There are certain differences, however, in their organization relationships to the Greater Boston Community Fund and the Council; and these differences produce inequities in the ways they are able to submit applications for Fund allotments and in the amount of money they receive. The differences are described in detail in the full Report. To bring an end to these inequities:

We Recommend: The appropriate Division of the Greater Boston Community Council should work with the three organizations to make the boundaries of their separate Councils as nearly co-terminous as possible with the boundaries of the Greater Boston Area; a uniform method of allocating funds to support the agencies should be worked out; and the services of the agencies in Municipal Boston should be expanded.

*Cambridge and Newton*

We said earlier that the plan of action outlined in this section of our Report would be centered on the City of Boston, but that it was generally applicable to other towns and cities in the Area. Cambridge and Newton are two communities in which this is particularly true.

There is immediate need in Newton for better integration of the operations of the Recreation Commission and the School Committee. Pertinent details are given in our full Report. Because the prime need is for better coordination of the tax-supported agencies and the voluntary agencies, the best plan would be for the Chairman of the School Committee and the Superintendent of Schools to be ex-officio members of the Recreation Commission.

The immediate need in Cambridge is also for an objective analysis and plan for coordination of tax-supported and voluntary agency programs. The Planning Board and the Cambridge Community Federation should promptly join in developing a plan for relating the voluntary agency facilities to the plan of expanded tax-supported facilities. The program of the Recreation Commission and the voluntary agencies should be coordinated. This applies particularly, as developed in our full Report, to the Boys' Club; the YM and YWCA'S: and the Neighborhood Houses and Settlements.

Both Cambridge and Newton are providing a floor of tax-supported facilities which surpasses the floor provided by most of the communities in Greater Boston, but the developments of the voluntary agencies are little related to this floor. Cambridge has an active Planning Board which has recently approved and circulated a plan of expansion for the tax-supported facilities and services A group in Newton is working toward the same end. Both communities have active Recreation Commissions with qualified leadership.

We Recommend: The appropriate Division of the Greater Boston Community Council initiate at once, in Cambridge and Newton, through the proper channels, an objective study of the play, recreation and group experience programs in each of these communities in the light of the general principles and recommendations of this Report.

*Camping Services*

The camping services offered by the voluntary agencies of the Greater Boston Area are extensive. No detailed study of them was made. Rather, the general organization of these services was reviewed

as they relate to the community, the Community Fund and Community Council, the different agencies, and the manner in which referrals are handled.

In general, the organization of camping services in the Area reflects the pattern of agency operation which has grown up through the years. A multiplicity of camps and camping organizations exists, each offering services to boys and girls throughout the Area. The general plan outlined in this report of relating and simplifying agency relationships and program operations is also applicable to camping services.

Several present practices relating to the camp operations of many agencies highlight the need for better organization. As detailed in our full Report, the existing budgeting procedure of such agencies makes it impossible to segregate, as a routine matter, money spent for camping purposes and thus to know currently the total costs of camping operations. The present method of making referrals for acceptance of children for camps is far from uniform, with a resulting waste of much valuable time in "shopping around" by the personnel of many agencies. To cure these two weaknesses, we offer the following recommendations (Nos. 64 and 65 in our full Report):

We Recommend: The Greater Boston Community Fund should establish a budget procedure which will set out in a separate item all monies which are budgeted for the provision of camping service by agencies not operating camps and for the costs of camp operation by agencies that do operate camps.

We Recommend: The Greater Boston Community Council should establish as a part of the Camp Section:

(a) A central camp registry office to handle all referrals to camps affiliated with the Council. This office should: (a) clear and process all referrals for camping service by agencies not operating camps, (b) be given complete authority and responsibility in matters pertaining to camp placement by these agencies; and (c) establish a uniform tuition for camping service to be provided these agencies.

(b) A budgeting service procedure for all budgets for camp operation or the provision of camping service by its member agencies. It would be well to establish a central disbursing office where all funds allocated for the provision of camping service by agencies not operating camps could be disbursed. These funds could be held by the Greater Boston Community Fund to be disbursed on the order of this office.

(c) A coordinating and information service office to assist and guide agencies operating camps and the general public with respect to camp operations and services.

Many of the Neighborhood Houses and Settlements in Greater Boston are camp-operating agencies. With the consolidation of many of these agencies as we have recommended, some action will be necessary to reorganize their camp holdings and operations. In view of the fact that the proposed new role for these agencies will gradually relieve them of the responsibility for operating organized programs of play, recreation and group experience, which includes camps, these agencies should be divorced from camp operations. Therefore we submit the following recommendation (No 66 in our full Report):

We Recommend: The Greater Boston Community Council should arrange with the representatives of the Neighborhood Houses and Settlements and The Boys' and Girls' Camps, Inc., a procedure under which The Boys' and Girls' Camps, Inc., will assume the operation of all camps now operated by Neighborhood Houses and Settlements which are deemed adequate and essential for operation; or, alternatively, a separate Camp Operation Organization should be created and established for this purpose. The cost of operating such camps should be covered by allotments from the Greater Boston Community Fund for the purpose, and The Boys' and Girls' Camps, Inc., should become a member of the Greater Boston Community Fund and the Greater Boston Community Council.

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*The Executive Committee of the Survey dissents in part from the Staff Recommendations as to Camping Services, for the following reasons:*

*"1. In view of the expenditure of over $1,000,000 a year by voluntary agencies for camping services, and in view of the confusion and wastage of effort resulting from the multitude of individual camp operations which seek support from the public at large through the Community Fund, the Executive Committee supports Recommendation No. 64 (standard camping budgeting procedure) and No. 65 (central camping registry; coordinating and information service; and camp budgeting service procedure).*

*"2. As to Recommendation No. 66, the Executive Committee, of course, agrees that the Boys' and*

*Girls' Camps, Inc., the largest organization in the camping field, should have membership in the Fund and Council and participate fully in making camping plans for the Greater Boston Community.*

*"3. The Executive Committee believes that the Community Council and the agencies concerned, in cooperatively working out into actual practice Recommendations Nos. 64, 65, and 66, should undertake to preserve a measure of the allegiance of the individual camp to its present sponsor. In that allegiance, and the related intake policy, lies great value. While preservation of such value may be inconsistent in many cases with merger and consolidation of individual camps into the Boys' and Girls' Camps, Inc., or into a separate Camp Operation Organization, it is not inconsistent with a reasonable and prudent scheme for centralization of financing, budgeting, purchasing, and overhead administration."*

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## VII. Planning and Financial Services

In the field of Planning and Financing, the Survey addressed itself to the following questions:

1. What are the most desirable relations between —
   a. The Greater Boston Community Fund and the Greater Boston Community Council;
   b. The Greater Boston Community Fund and the chests in the Metropolitan Area;
   c. The Greater Boston Community Council and the councils in the Metropolitan Area; and
   d. The Greater Boston Community Council and the Hospital Council, the Health League, and the Nursing Council?
2. What is the most desirable budgeting process for the Greater Boston Community Fund to adopt?
3. What program should be developed to deal with the multiplicity of organized fund-raising efforts now being made throughout the Area?
4. Are the amounts annually expended by the Greater Boston Community Fund for service, budgeting, education, planning and similar objects too large or too small?
5. Is there need in the interest of better community planning, for greater coordination than now exists between private charitable foundations in Greater Boston, the Greater Boston Community Fund, the Greater Boston Community Council, and public agencies in Greater Boston?

### *I. The Basic Recommendation**

It is obvious that in considering the central planning and financing machinery the entire health and welfare needs and services of the Greater Boston Area should be borne in mind.

Our study of the records of the Greater Boston Community Council and the Greater Boston Community Fund, and consultation with a large number of individuals and committees active in both organizations, as well as with persons concerned primarily with agency programs, convinced us that

1. An effective planning body for the Greater Boston Area should have greater strength and prestige than the Council now has;
2. The barrier now erected between so-called "Fund people" and "Council people" is artificial, unfortunate, and unnecessary, and should be broken down, because both groups have the same fundamental interests;
3. Campaign workers can become interested in planning and vice-versa;
4. Present duplication of activities between Fund and Council should and can be avoided;
5. The interest of public and other non-Fund agencies in planning should and can be increased; and
6. Staff of the needed high quality can be obtained in the central organization, whatever its form.

With these and other considerations in mind, we believe that, all things considered, the best way to meet the problems of the Greater Boston Area is through the formation of a single new organization to discharge the functions of planning, fund-raising, and budgeting, as well as the additional service functions, now discharged by the Greater Boston Community Council and the Greater Boston Community Fund. We do not propose that the Fund absorb the Council or the Council absorb the Fund. We propose that a new corporation be organized better to assist the citizens of Greater Boston to serve the needs of the community in the health and welfare fields. Therefore —

*Our study of Planning and Financing Services was made by a Panel of three persons — John B. Dawson, Robert H. MacRae, and Herman D. Smith (Chairman). Messrs. Smith and MacRae join in all the findings and recommendations presented herewith. Regarding the Basic Recommendation, Mr. Dawson filed a Minority Report expressing the following reservation: While he does not discount the possibilities of a single organization, he believes the choice of one form of organization or another cannot be surely reached through the Survey method and is likely to be more fully and realistically explored, and in the end more generally accepted, by means of joint deliberation on the part of those most closely and directly concerned. He considers that a recommendation in advance of such action would be out of place; and his Minority Report contains a recommendation specifying the conference procedures he believes essential. If a single organization is established, however, Mr. Dawson subscribes to the proposals made here and later regarding its functions and structure. The Minority Report and a Supplementary Memorandum filed by Mr. Dawson are contained in our full Report on Planning and Financing.

We Recommend: (1) A new organization should be created, which should discharge the functions of planning, fund-raising, and budgeting, and also the additional service functions now discharged by the Greater Boston Community Council and the Greater Boston Community Fund. To this end, the present Council and Fund should be dissolved.

We emphasize that the organization we have in mind is not designed as a consolidation of existing organizations, but as an entirely new organization. For this reason, we think the organization should receive a title which would not suggest either of the existing organizations. We suggest "Greater Boston Health and Welfare Federation" or "Community Service Federation of Greater Boston."

## *II. General Structure and Functions of Proposed Organization*

### A. Board of Directors

It is important to insure a proper balance of the three main functions in the new organization. The first and most essential safeguard will lie in the composition of its Board of Directors. By providing that the Board include diversified points of view, representing voluntary and governmental services alike, and by including on it a considerable proportion of agency Board members with a broad outlook as regards planning, money-raising and budgeting, as well as a substantial proportion of representatives of the community at large, a proper balance between the three elements should be obtainable.

We Recommend: (2) (a) The Board of Directors of the new organization should contain representatives of the boards of Fund-supported agencies, the boards of non-Fund voluntary agencies, Metropolitan Chests and Councils, public agencies, professional social workers*, and the community at large, including labor and religious leadership.

(b) The first Board of Directors of the new organization should be elected by a delegate body composed of delegates from agency members of the present Greater Boston Community Fund and/or the present Greater Boston Community Council, delegates from Chests and/or Councils in the Metropolitan Area, and delegates at large named jointly by the Boards (or Presidents) of the present Greater Boston Community Fund and the present Greater Boston Community Council. Provision for a permanent Delegate Body should be made in the constitution of the new organization.

(c) Executive direction of the new organization should be vested in a person chosen by the Board of Directors, responsible to that Board, and competent to administer the entire varied and large scale program outlined below.

### B. Departments

The proposed organization should have three principal Departments — Fund-Raising, Budget and Planning, each of which should enjoy a large measure of freedom of action, subject to the general approval of the Board of Directors. There will also be need of certain Service Departments.

#### 1. *Fund-Raising Department*

As the name implies, this Department should be responsible for planning and conducting the annual campaign on behalf of the voluntary agencies which receive allotments. In charge of the work of the Fund-Raising Department there should be an Executive Committee, named by the President of the new organization and confirmed by the Board of Directors. We assume that the customary campaign structure will be organized under this Executive Committee's supervision and direction.

We Recommend: (3) (a) Subject to confirmation by the Board of Directors, the President of the new organization should be authorized to appoint the Chairman and members of an Executive Committee to direct and supervise the work of the Fund-Raising Department.

(b) Executive direction of the Fund-Raising Department should be vested in a competent and experienced campaign manager who should be administratively responsible to the Executive Director of the entire organization.

#### 2. *Budget Department*

The confidence of the public in the new organization will be dependent in large part on the competence with which the entire budgeting operation is conducted. As is now the practice, it will be necessary to have both a Central Budget committee and functional or group budget committees.

We Recommend: (4) (a) Subject to confirmation by the Board of Directors, the President of the new organization should be authorized to appoint the Chairman and members of a Central Budget Committee to direct and supervise the work of the Budget Department.

*As used in this section of our Report, the expression "professional social workers", or any similar expression, means professional staff members of participating agencies.

(b) Subject to confirmation by the Central Budget Committee, the Chairman thereof should be authorized to appoint the Chairmen and members of such functional or group budget committees as the Central Budget Committee may determine.

(c) Executive direction of the Budget Department should be vested in a competent person, skilled in budgeting methods, who should be administratively responsible to the Executive Director of the entire organization.

*The Budget Process.* The budget process of the Greater Boston Community Fund still reflects early agency resistance to federated financing, and early doubts and questions by towns and cities in the Metropolitan Area about the validity of the Greater Boston concept. Progress in overcoming these obstacles has been made, and the leadership of the community, both lay and professional, is intelligently aware of the present shortcomings. The following recommendation is offered for strengthening the budgeting process:

We Recommend: (5) (a) The Central Budget Committee should distribute to agencies a statement of general policies for their guidance. This statement should cover such items as requirement of audits, policy on recovery of surpluses, control of benefits, necessity for consultation on proposed changes in program, etc.

(b) The annual budget form submitted and signed by an agency should include a re-statement and re-affirmation of the principal terms of membership.

(c) The Budget Department should prepare, in consultation with member agencies, a uniform classification of agency accounts.

(d) Further study should be given to the job classification-salary range system proposed by the Council, with a view to the adoption of some such plan.

*Budgeting in the Central Office.* Although members of the Panel believe that the budgeting function has been exercised with considerable skill and competence, they also believe that it would be more effective if even a closer liaison were established with the Planning Department. To this end —

We Recommend: (6) Secretaries of the functional Divisions of the Planning Department should serve as technical consultants of functional or group budget committees. Such staff members should be used for professional services only, not for the scheduling meetings and similar routine matters. Other members of the Planning Department staff should be used as resource people whenever such use would be helpful to the budget committees.

*Budgeting of Agencies in Municipal Boston.* Agency budgeting in Municipal Boston is done on a functional basis. We think this is the way budgeting should be done.

We Recommend: (7) (a) Budgeting of agencies in Municipal Boston should continue to be done on a functional basis.

(b) An opportunity to appeal to the Central Budget Committee before final action is taken by that Committee should be guaranteed to agencies in Municipal Boston. The right of appeal beyond the Central Budget Committee to the Board of Directors should be preserved.

*Budgeting of Agencies in the Metropolitan Area.* Agency budgeting in the Metropolitan Area is done on a geographical basis. Persons with whom we talked in Boston admitted that this difference in approach leads to inequities, and a recent analysis demonstrated this fact vividly. Reasons for the weaknesses inevitable in this dual method of budgeting are given in some detail in our full Report on Planning and Financing. Specifically, we question the value of the intermediate Metropolitan Budget Committees. We understand the Greater Boston Community Council has also questioned their value and recommended their discontinuance.

We Recommend: (8) (a) The advisory recommendations of local chests should be transmitted directly to the appropriate functional budget committee for review in the same manner as the budgets of Boston agencies are now reviewed. Presentation of the action of a local chest could be made to the functional budget committee either by a representative of the local chest, or by a representative of the local agency, or by both, as may be locally determined.

(b) The present Metropolitan Budget Committees should be discontinued.

We Further Recommend: (9) (a) The findings and recommendations of the functional budget committees in regard to the budgets of agencies in the Metropolitan Area should be transmitted to the Central Budget Committee for final determination.

(b) The report of functional budget committees to the Central Budget Committee should contain two analyses of the budgets of agencies in the Metropolitan Area — one functional and one geographic.

(c) The recommendations of the functional budget committees in regard to the budgets of agencies in the Metropolitan Area should be reported back to local chests, with the advice that said recommendations are being transmitted to the Central Budget Committee for final determination.

(d) An opportunity to appeal to the Central Budget Committee before final action is taken by that Committee should be guaranteed to local chests. The right of appeal beyond the Central Budget Committee to the Board of Directors should be preserved.

3. *Planning Department**

In one sense every health and welfare agency is a planning body. But community planning is something far more than agency planning. And a Greater Boston community planning body, if it means anything, is something more than a Council of Social Agencies. The Greater Boston Community Council is still primarily a council of agencies and more particularly a council of agencies located in Municipal Boston. Twenty years ago this sort of council may have been satisfactory, but the public's attitude toward health and welfare planning is changing. Such planning is being more and more widely regarded, not as the virtually exclusive prerogative of existing agencies, with their special interests and points of view, but as a task in which all elements concerned with community well-being should take part, especially the contributing element.

In charge of the Planning Department, there should be an Executive Committee, the majority of whose members should be lay persons drawn from the boards of Fund and non-Fund voluntary agencies, of Chests and/or Councils in the Metropolitan Area, from public agencies, and especially from the community at large.

We Recommend: (10) (a) Subject to confirmation by the Board of Directors, the President of the new organization should be authorized to appoint the Chairman and members of an Executive Committee to supervise and direct the work of the Planning Department.

(b) The majority of such Executive Committee should be lay persons drawn from the boards of Fund and non-Fund voluntary agencies, from public agencies, from Chests and/or Councils in the Metropolitan Area, and from the community at large. There should be some professional social workers on the Executive Committee, but they should be a small minority of the full membership.

(c) Executive direction of the Planning Department should be vested in a competent person experienced in health and welfare planning, who should be administratively responsible to the Executive Director of the entire organization.

*Citizen Participation.* The present Council has made little or no provision for participation by citizens other than those officially appointed by and representative of the member agencies. It is one of the few large Councils in the country which has no provision for "delegates at large" as distinct from delegates appointed to represent agency interests.

We Recommend: (11) The Planning Department should include in its total membership and in all committees which have to do with general policy and planning an adequate representation of citizen interests in addition to those officially identified with agency interests.

*Balance between Lay and Professional Participation.* Even when there is in theory a sound balance between lay and professional representation, in practice the drift is often toward a preponderance of professional participation, unless there is conscious and sustained effort to prevent it. This is not good for the planning body, the community, or for professional workers.

We Recommend: (12) Although the policy-making and planning groups in the Planning Department may properly include professionals as voting members, the majority in such groups should be composed of lay men and women qualified and able to render active service.

*Geographic Planning*— (a) *In Municipal Boston.* Through a Committee on Local Social Planning, the present Council provides an advisory, consultative and promotional service to planning bodies in the 54 cities and towns in the Metropolitan Area and theoretically at least to the 15 Health and Welfare Areas in Municipal Boston itself. At the present time, due to lack of funds, there is no staff service exclusively assigned to planning in Municipal Boston.

It seems to have been assumed that the present Board could undertake direct responsibility for planning in Municipal Boston and advisory responsibility with respect to planning in the 54 cities and towns in the Metropol tan Area. This assumption is erroneous. If local community planning is good and necessary for Somerville, Cambridge, Newton and other Metropolitan cities and towns, it is good for Municipal Boston.

*Mr. Dawson joins in the recommendations for a re-organized planning body, whether it is a separate organization or a department of a new organization.

We Recommend: (13) Within the Planning Department, a planning group for Municipal Boston should be organized, starting with the present natural areas of interest in the City, with due representation of local citizen interests, using the functional Divisions as resource bodies for local planning.

*Geographic Planning* — (b) *In the Metropolitan Area.* The problems of relationships between a large city and its surrounding communities are always difficult. In Greater Boston these problems are compounded by intense local community loyalties. The complexity of this problem and the nature of the organization established to work with it are matters of great concern.

To complicate things further, this most vital and difficult area in the field of planning, while assigned to a Council Committee on Local Social Planning, has been served by a planning staff which has served the Metropolitan Division of the Fund as well. Four of its five members, including the executive, are on the Fund payroll and are housed in Fund offices. It is not surprising that in the course of time it has become chiefly identified as a Fund staff.

In those communities where Chests and Councils did not exist prior to the creation of the Greater Boston Community Fund, the geographic staff has proceeded with the organization of Chests and/or Council. It is quite clear that the present geographic staff cannot service adequately this substantial number of Community Chests and Councils. It is even more evident that the present functional staff of the Council is entirely unable to provide service to this regiment of organizations. We think the practice of organizing chests and/or councils, community by community, should be discontinued, and that a new long-term strategy in facing this problem be undertaken. This strategy should be a purposeful effort to effect groupings or combinations of Metropolitan towns and cities in natural regions of interest in order to reduce the number of administrative units and provide a more manageable operation.

We Recommend: (14) (a) The policy of organizing chests and/or councils, community by community throughout the Metropolitan Area, should be discontinued.

(b) As a substitute for the policy to be discontinued, as recommended in section (a) of this recommendation, a new policy should be adopted of effecting regional groupings of towns and cities in the Metropolitan Area, and of organizing region-wide chests and/or councils in such regions.

(c) The present Committee on Local Social Planning should be abolished. To take its place, the Chairman of the Executive Committee of the Planning Department should be authorized to appoint, subject to confirmation by the Executive Committee, a new committee on local social planning. The composition and duties of this new committee should conform to sections (d) and (e) of this recommendation.

(d) The majority of the new committee on local social planning should be lay men and women. They should be representatives of local and regional chests and/or councils (including the planning body organized for Municipal Boston), serving on a rotating basis, and citizens representing the community at large.

(e) The duties of the new committee on local social planning should be to promote the policy of effecting regional groupings of cities and towns in the Metropolitan Area; to organize chests and/or councils in such regions as judgment may direct; to pool the experience of the several communities (including communities in Municipal Boston); to advise the governing bodies of the entire organization and the principal Departments on matters of policy; and to counsel with the staff.

(f) Local and regional chests and/or councils should be given due weight on the Board of Directors of the new organization, on the Executive Committees of the principal Departments, and on all appropriate committees.

(g) Staff members responsible for local planning in Municipal Boston and in the Metropolitan Area should be attached to the Planning Department; should be free to call on the secretaries of the functional Divisions as a resource staff; and should receive specific assignment to such fund-raising duties and for such periods of time, under the direction of the Fund-raising Department, as may be required.

*The Functional Divisions.* The functional Divisions should be regarded primarily as the great media for pooling total experience in the several fields of work. Together with the Research Department, they are invaluable sources of information in social planning. Each Division should be broadly representative of its field; its membership should be as inclusive as possible of agencies and interests in the several fields of work throughout the entire Greater Boston Area; and in its executive, standing and special committees, there should be adequate provision for lay participation not only on the part of agency delegates but others who are interested in the job to be done but who have no official agency connection.

We Recommend: (15) (a) Functional Divisions organized within the Planning Department should be regarded primarily as sources of information and advice for local planning bodies, for the new committee on local social planning, and for the Executive Committee of the Planning Department.

(b) Voluntary and public agencies in the Metropolitan Area should participate in the work of the functional Divisions on the same basis as agencies in Municipal Boston.

(c) Committees of the functional Divisions should be reconstituted so they will be more completely representative of all interests in the several fields and will have a larger proportion of lay members.

*The Range of Health and Welfare Planning.* Community-wide planning for health and welfare is in its infancy. In Greater Boston, as elsewhere, community planning in the real sense of the word, covering the full range of voluntary and tax-supported activities, has a long way to go.

We Recommend: (16) The central health and welfare planning body for the Greater Boston Area should include representatives of tax-supported and voluntary agencies so that it will achieve recognition as the planning body for all major health and welfare activities in the Area.

*Service Bureaus within the Planning Department.* The present Greater Boston Community Council has six "Cooperative Services" — namely, Research Bureau, Public Relations Bureau, Central Information and Referral Bureau, Volunteer Service Bureau, Camp Bureau, and the Social Service Index. All of these discharge useful and needed functions. We think the first four of these Bureaus should become Service Departments for all of the proposed new organization (the Central Information and Referral Bureau a unit in the Public Relations Department); and we think the Social Service Index and the Camp Bureau (if, after consideration of the recommendations on camping contained in the Divisional report on Recreation and Group Work Services, the Camp Bureau is continued) should remain with the planning body.

We Recommend: (17) The Director of the Social Service Index and the Director of the Camp Bureau (if that Bureau is continued) should continue to be administratively responsible to the Director of the Planning Department.

4. *Service Departments*

Four functions are now discharged by bureaus or departments in the Council or the Fund which we think should in future be discharged by strong departments serving all of the proposed new organization. These functions are research, public relations, central information and referral, and the recruitment and placement of volunteers. Our full report gives our reasons for thinking that these functions are important and should be vigorously performed in behalf of the entire organization.

We Recommend: (18) (a) Strong Departments of Research, Public Relations (including central information and referral service), Volunteer Service, and Office Management (including central accounting service to small agencies) should be established as Service Departments to the entire proposed new organization and its member agencies.

(b) The Directors of these Departments should be administratively responsible to the Executive Director of the entire organization.

(c) The Directors of the Research Department, the Public Relations Department, and the Volunteer Service Department should each have the guidance and support of competent advisory committees.

(d) All work of a research nature undertaken by the new organization should be done under the technical direction of the Director of the Research Department.

(e) Effective and helpful working relations should be established between the Research Department and appropriate graduate schools in Greater Boston, particularly the three schools of social work.

C. Relations between Planning Department and Less Inclusive Planning Bodies

At present four less inclusive planning bodies sustain somewhat indeterminate relations with the Greater Boston Community Council — i.e., they are neither wholly independent of the Community Council nor are they organic parts of it. These four planning bodies are the Hospital Council of Boston, the Boston Health League, Inc., the Greater Boston Nursing Council, and United Settlements of Greater Boston.

The task of planning for the health and welfare services of Greater Boston is intricate and embraces many functional fields and sub-fields. Yet we see it as an integral whole. We do not think independent or semi-independent bodies should assume responsibility for different parts of that whole. Therefore —

We Recommend: (19) (a) The Hospital Council of Boston, the Boston Health League, Inc., and

the Greater Boston Nursing Council should not be corporately separate from and independent of the Planning Department of the proposed new organization. Each should be a section of the Health and Hospitals Division of the Planning Department. The committee supervising the activities of each such section should be subordinate to the Executive Committee of the Planning Department and the Board of Directors of the entire organization; and the executive secretary of each section should be appointed by the governing body of such section in consultation with the Executive Director of the proposed new organization, and should be administratively responsible to the Director of the Planning Department and through him to the Executive Director of the entire organization.

(b) The Health and Hospitals Division of the Planning Department should be adequately represented on the Board of Directors of the proposed new organization and on all important planning committees thereof.

(c) The Board of Directors of the proposed new organization, the Executive Committee of the Planning Department, and the executives of the new organization and its Planning Department, should extend as large a measure of freedom of action to the sections of the Health and Hospitals Division as is consistent with sound planning and effective administration.

(d) There should be organized within the Planning Department an appropriate Division in the field of Recreation and Group Work Services, and appropriate sections within that Division, that include tax-supported as well as voluntary agencies. Thereafter the United Settlements of Greater Boston may continue as a voluntary association to advise that Division; but should not be recognized as a section of the Planning Department, and no funds of the Planning Department should be used for its support.

(e) There should be organized within the Planning Department an appropriate Division in the field of Family and Child Care Services, and appropriate Sections within that Division, that include tax-supported as well as voluntary agencies.

## *III. Additional Questions*

### A. Multiplicity of Fund-Raising Efforts

The confusion created in any community by the presence of many uncoordinated fund-raising efforts is serious. A partial list of such efforts shows that in the year ended October 31, 1948, ten organized campaigns were conducted in Greater Boston for announced total goals of well over $12,550,000 — all in addition to the Community Fund campaign for $6,600,000. Such a situation is a threat to many of the most essential services in the community.

There is only one sword with which to cut this Gordian Knot: a sense in the community's leaders of community discipline. Responsibility rests with the community leaders who sponsor, support and give direction to these miscellaneous campaigns. When they wish correction, they can bring it about.

Community leaders who believe in the continued effective operation of the community's voluntary health and welfare agencies, which federated financing makes possible, should take the initiative in devising remedies for the existing confusion. Order will be restored, budgetary controls will be instituted, and fund-raising will be related to needs only when community leaders determine they wish the job done through federation. The people who give the money and those who spend their energy to raise it have the right to determine how it shall be raised. Until they exercise that right in favor of federation, the present chaotic situation will continue. Chests, as the principal proponents of federated financing, have the responsibility to take the initiative in bringing about federation.

### B. Expenditures for Service, Budgeting, Education, Planning, Etc.

We have no reason to think too much money is being spent on any of the functions listed above. We have outlined the kind of organization we think should be established; and as regards the Planning Department, we are convinced that what we have described is the kind of planning body called for, whether it is a department of a single organization or an independent council. Such a planning body, with leadership and staff qualified to do the planning job the community wishes done, will cost a substantial amount of money. We think the important thing is to decide on the job to be done, and on the kind of organization best fitted to do the job, and then to pay what is required to obtain good people to make that organization effective. With the drastic reconstruction recommended here for the central organizations, and elsewhere for many of the direct service agencies, we think it vital to look forward and unprofitable to look backward.

### C. Better Cooperation between the Sources of Funds

There is no doubt in our minds that there is obvious need for greater coordination among large contributors to social and health agencies, or that this need should be recognized by community leaders in Greater Boston and steps taken to meet it. Health and welfare services are financed from three main sources — tax funds, voluntary contributions by individual donors (including business firms, organized labor and other employee groups), and private foundations. Within limits, community funds and councils provide coordination of planning and financing as regards voluntary contributions by individual donors. But use of such contributions is normally planned with little knowledge of what private foundations will do in the same field, and with not too much attention to what will be done by legislatures or other public appropriating bodies. The same statement is true in reverse. Public appropriating bodies usually pay little heed to what is or may be done by the other two chief sources of support for health and welfare services; and private foundations, in their turn, too often make their grants largely on the basis of the agencies' own presentation of need, neither invoking nor desiring to share in the community disciplines which funds and councils try to exert. All this makes true central planning of health and welfare services difficult, if not impossible.

We think it would be a fine and forward-looking act if all three of the major sources of funds for health and welfare services, and especially the two groups that direct most of the voluntary contributions, should engage in free exchange of information and clearance of all important plans. In Kansas City, Missouri, four private foundations have taken a significant step in this direction, the purpose of which is merely to make sure that each foundation knows what other foundations and the Community Chest are doing or planning to do before its own plans crystallize, so that it may act in full knowledge of pertinent facts; and to insure the orderly and harmonious development of privately financed health and welfare activities in the community. The same purpose would be served on a broader scale in Greater Boston if the following recommendation, which we strongly advocate, is carried out:

We Recommend: (20) The officers of the proposed new organization should take the initiative in developing a procedure which would result in an exchange of information about plans for the support of health and welfare services among the appropriate committees of the new organization, the officers of private foundations, and public appropriating bodies throughout Greater Boston.

# PART FOUR

## VIII. Priorities

No community is able to raise enough money, in tax-funds and voluntary contributions combined, to meet in full all the demonstrable social and health needs of its residents. Hence the task of allocating to social and health services the money that can be raised is a hard one. Choices must be made between fields of service, and between services within each field. The question of *priorities,* therefore, is always acute and never easy.

After every community survey the question becomes acute for an added reason. Survey reports are apt to call for substantial changes in prevailing service patterns; and while such changes can usually be made over a period of years, they can hardly ever be all made at once. Limitations of time and manpower intervene, added to limitations of funds. Most survey committees, therefore, look to the survey staff not only for findings and recommendations in each field of service; they look also for recommendations, or at least advice, as to which of the many specific recommendations contained in the staff reports should receive chief emphasis. The Executive Committee of the Greater Boston Community Survey is no exception.

It is not easy, or in some cases even possible, to obtain such advice from a survey staff as a whole. A survey staff is composed of specialists in different fields, and specialists are notoriously and laudably partial to the fields in which they have worked and about which they know the most. In the present instance, the Director of the Survey did not ask his staff associates for their composite opinion on "priorities." Instead, he agreed to submit a set of "priorities" on his own responsibility.

The purpose of social and health services is to meet certain human needs. But human "needs" are relative. Some things, such as food, clothing and shelter, are needed in a sense that other things are not needed. The more fundamental needs, without which neither efficient activity nor even life itself is possible, can be thought of as *primary;* less fundamental needs, as *secondary.* Within the categories of need which social and health services are designed to meet, some such broad classification is helpful. It is necessary to remember, too, that we must think of need in mass terms. In the life of a particular child there may be periods when association with other children is more necessary than adequate diet for happy growth; but society cannot plan services for large numbers of people exclusively in terms of special cases. We must plan for the greatest good of the greatest number, and hence must think first of meeting the *primary* needs of many people. *Secondary* needs, and the special needs of people with special difficulties, can be met if and when the *primary* needs of large numbers have been taken care of.

This line of reasoning, however, is subject to one important qualification. In the social and health field we are dealing with people as they are, and the people we deal with include the general public — moral and financial supporters of social and health services — as well as the persons benefiting directly from those services. We cannot, therefore, even if we wished to do so, make a violent break with all of the past and present. If we tried, we should alienate too much of the support that is indispensable to what we seek to improve. Moreover, all of us, no matter how self-reliant we deem ourselves, benefit indirecty and even directly from all the social and health services of the community in which we live.

Let us now proceed to state specific "priorities":

1. Greater Boston's paramount social and health need at present is a planning body, formed by cooperative action of citizens of good will and capable of giving order, proportion and direction to the development of direct service agencies. Without such a body, confusion, waste and inefficient service are inevitable. A dollar spent for sound planning at the center will yield many dollars' worth of improved service at the point of agency contacts with clients.

2. Qualifications for agency personnel should be raised. Plans, however sound, are worth little without competent people to carry them out.

3. Hospitals are a community's first line of defense against the most potent of all destroyers of human happiness, — disease and death. There must be enough of them and they must be secure. Hospital beds in Greater Boston should be made adequate in number and kind; and hospitals should be put on a strong financial base through improvement in their own schedule of fees; through more adequate payments by third parties, especially Blue Cross and public agencies for whose clients the hospitals care; and through operating economies.

4. More far reaching even than the services of hospitals, though less urgent at any given moment, are the services of agencies devoted to the protection and promotion of health. Of our health recom-

mendations, the most urgent deal with "Health Unions" and other proposals for strengthening health services in the Metropolitan Area; and with strengthening the Visiting Nurse Association of Boston, especially its financial position.

5. In the social as distinct from the health field, individual services to families, children and adults have prior claim to attention in Greater Boston; and among such services, those of family agencies are basic, with those of child care agencies coming next. There should be a Federation for family service, with its Social Service Centers as focal points of service, screening, information and referral. Allied to this, order and increased strength should be introduced into the child care field in the manner we propose.

6. In the recreation and group work field, three lines of improvement are selected for chief emphasis: (a) Voluntary and tax-supported recreation activities should be planned together as a unified program, instead of being planned quite separately as at present. (b) Agencies which have expanded their original programs by adding other and not too closely related services that are the primary function of other specialized agencies should divest themselves of services not germane to their central purpose. (c) Appropriate agencies should conduct joint activities; and the administrations, and eventually the corporate entities, of many agencies of like function and physical proximity should be merged and consolidated.

In using the expression "priorities" and in giving each a number, there is no suggestion that action should be undertaken in chronological order — the first completed before the second is begun, the second before the third, etc. It is assumed that they will be undertaken more or less simultaneously. The use of numbers is an attempt to indicate a *relative importance in the situation in which Greater Boston now finds itself* — with hundreds of established agencies doing work of varying degrees of consequence and excellence, and with valid requests made by those agencies for more money than the community has been able to raise. It is not implied that action on any specific recommendation in our Reports should be postponed until these "priorities" have been satisfied.

R. P. L.

# ANNEX I

## Index of Social Need*

The Index of Social Need was constructed by the Survey Statistical staff as a measure that would make possible the ranking of 69 communities (the 15 Health and Welfare Areas of Boston and the 54 cities and towns of the Metropolitan Area) so as to permit comparison of their relative need for health and welfare services.

The Index for each community is based on 12 factors that indicate economic, social and health conditions in the community:

1. Infant Mortality Rate
2. Tuberculosis Rate for New Cases
3. Tuberculosis Death Rate
4. Median Rent
5. Juvenile Delinquency Rate
6. Massachusetts Society for the Prevention of Cruelty to Children Case Rate
7. Percentage of Overcrowded Households
8. Percentage of Households Needing Major Repairs
9. Old Age Assistance Rate
10. Aid to Dependent Children Rate
11. Percentage of Non-White and Foreign-Born White in Population
12. Percentage of Population Gained or Lost

Of these 12 factors, the first 8 give a direct measure of recognized health and welfare needs. Factors 9 and 10 measure the community's response to needs that are presumed to be cared for uniformly and fully under existing statutes, and that also indicate general economic status within each community. In addition, factor 10 to some extent indicates the volume of need in families with children. Factor 11 measures somewhat the degree to which a community is culturally non-homogeneous and hence the degree to which social and cultural barriers restrict economic and social opportunities for these groups.

Factor 12 is of value as follows: (a) Where communities are actually losing population, the explanation is usually considered to be either fewer work opportunities or deterioration of the area as a residence location. Moreover, only fairly densely populated areas are likely to decrease in population, and in highly urbanized areas population density is correlated with need. (b) Only communities with considerable surplus land area can show large increases in population, and surplus land area is a social and health asset.

The Survey's statistical consultants constructed a composite Index Number, based on the index numbers for each of the 12 factors, and ranked the 69 communities accordingly. The higher the Index Number, the greater the need. The Index Number of each of the 69 communities is as follows:

| RANK ORDER | COMMUNITY | INDEX NUMBER |
|---|---|---|
| 1 | South End | 164 |
| 2 | North End | 157 |
| 3.5 | Charlestown | 146 |
| 3.5 | Roxbury | 146 |
| 5 | South Boston | 140 |
| 6 | East Boston | 134 |
| 7.5 | West End | 132 |
| 7.5 | Chelsea | 132 |
| 9 | Cambridge | 124 |
| 10 | Dorchester No. | 123 |
| 11 | Burlington | 122 |
| 12 | Jamaica Plain | 121 |
| 14.5 | Somerville | 116 |
| 14.5 | Hyde Park | 116 |
| 14.5 | Woburn | 116 |
| 14.5 | Everett | 116 |
| 17.5 | Waltham | 115 |
| 17.5 | Revere | 115 |
| 19 | Malden | 114 |
| 20 | Brighton | 109 |
| 21 | Norwood | 108 |
| 23.5 | Dorchester So. | 107 |
| 23.5 | Back Bay | 107 |
| 23.5 | Watertown | 107 |
| 23.5 | Wayland | 107 |
| 26.5 | Canton | 106 |
| 26.5 | Dedham | 106 |
| 28 | Quincy | 104 |
| 30 | Natick | 103 |
| 30 | Weymouth | 103 |
| 30 | Wakefield | 103 |
| 32.5 | Sherborn | 101 |
| 32.5 | Braintree | 101 |
| 35 | Norwell | 100 |
| 35 | Sharon | 100 |
| 35 | Roslindale | 100 |
| 37 | Stoneham | 99 |
| 38.5 | Walpole | 98 |
| 38.5 | Lexington | 98 |
| 40.5 | Medford | 97 |
| 40.5 | Reading | 97 |
| 42 | Holliston | 96 |
| 44.5 | Sudbury | 94 |
| 44.5 | Bedford | 94 |
| 44.5 | Millis | 94 |
| 44.5 | Brookline | 94 |
| 48 | Hull | 92 |
| 48 | North Reading | 92 |
| 48 | Carlisle | 92 |
| 50 | Medfield | 91 |
| 51 | West Roxbury | 90 |
| 52 | Melrose | 88 |
| 54 | Arlington | 87 |
| 54 | Scituate | 87 |
| 54 | Needham | 87 |
| 56 | Acton | 86 |
| 57 | Newton | 85 |
| 58.5 | Winthrop | 84 |
| 58.5 | Concord | 84 |
| 60 | Hingham | 82 |
| 61 | Cohasset | 80 |
| 62 | Winchester | 77 |
| 63 | Weston | 75 |
| 65 | Wellesley | 72 |
| 65 | Lincoln | 72 |
| 65 | Dover | 72 |
| 67 | Belmont | 71 |
| 68 | Westwood | 70 |
| 69 | Milton | 66 |

* A memorandum fully discussing the technical aspects of the construction of the Index of Social Need is included among the Survey material filed with the Greater Boston Community Council (Research Bureau). That memorandum — and much work on the Index — was done by Walter I. Wardwell, a graduate student at Harvard College; working under the supervision of Dr. R. Clyde White, Director of the Survey's Division of Statistics and in consultation with Dr. Morris B. Lambie, Professor of Government and Tutor in the Department of Government at Harvard College, and Dr. Samuel A. Stouffer, Professor of Sociology at Harvard College.

# ANNEX II

## Personnel Turnover in 150 Public and Voluntary Social and Health Agencies in Greater Boston, 1947[1]

This Study was undertaken to determine *first*, the extent to which turnover of personnel is regarded as a problem by selected social and health agencies; *second*, the amount of turnover in these agencies; and *third*, the amount and effect of such factors as part-time staff and the seasonal nature of work on the turnover situation.

Some turnover is unavoidable, some is desirable, much is preventable. All turnover, however, is extremely costly in actual dollar expense of breaking in new workers; and often it is costly, too, in its adverse effects on other workers who must carry additional burdens, and on persons served who must experience gaps and shifts in service and adjust to new workers. Business and industrial firms have found that the average cost of labor turnover to employees is $8.50 per laborer, about $59.00 for a typical semi-skilled worker, and $250.00 for a skilled employee. [2]

The study included a total of 150 agencies as follows: 17 public agencies of various kinds; 13 voluntary health agencies, 41 voluntary casework agencies; 49 voluntary recreation and group work agencies; 24 voluntary hospitals; and 6 homes for the aged. All had 5 or more employees. As of January 1, 1948, these agencies had 5,204 full-time employees and 1,644 part-time employees. Except when otherwise stated, all discussion is in terms of full-time employees only.

*Recognition of turnover as a problem.* In reply to the question "Is staff turnover a particular problem in your agency?" 27 percent of the agencies said that it was; 58 percent said its was not; and 15 percent either were not sure or did not answer. When turnover rates are examined for the agencies which said it was not a particular problem, there were found to be 21 agencies with a turnover rate of 50 percent or over; that is, they had 50 or more separations from service within tbe year 1947 for every 100 employees on the payroll as of January 1, 1947. The fact that these agencies did not consider such turnover to be a particular problem may mean that a long existing situation, even if regarded as undesirable, may not be considered a "particular" problem or it may mean that the undesirability of such turnover is not recognized. However the agencies may regard it, a turnover of 50 percent or more does present a problem for efficiency and economy of operation. The 22 additional agencies where turnover rates were between 30 and 40 percent might also be considered to present problems worthy of agency attention.

*Amount of Turnover.* In the 150 agencies, the number of separations in 1947 were as follows:

| | |
|---|---|
| Maintenance employees | 1,723 |
| Office employees | 311 |
| Professional employees | 1,120 |

The total turnover for all the agencies (see table 4 in full Report) is sbown to be 62 percent. In the absence of comparable figures from other communities for these types of employment, it cannot be affirmed that this represents a less favorable situation than exists in health and welfare fields elsewhere. However, the 1947 national figure for turnover in manufacturing is about 57 percent[3]. As manufacturing is subject to layoffs and seasonal factors to a far greater degree than social and health services, this turnover rate of 62 percent in health and welfare employment in Greater Boston appears to be very high.

The turnover rate for professional workers was 47 percent; for office workers, 36 percent; and for maintenance, workers, 95 percent. Again, in the absence of data from other communities, it cannot be affirmed that these figures are high as compared with similar operations elsewhere; but it is clear that such rates of turnover must be costly and often disrupting to the smooth operation of services.

Turnover among supervisors is characteristically lower than among "workers." In evaluating this it must be remembered that replacement of one supervisor is usually more costly than replacement of several workers.

The highest turnover rate is shown in homes for the aged. However, only 6 homes were in the Study; their turnover rate of 141 percent reflects an extremely high rate in one home and hence it may not apply generally to all homes. Therefore the correspondingly high rates for various classes of employees in such homes will be omitted from all the comparisons which follow.

The turnover rate in hospital employees is 87 percent. This rate is much higher than in other types of agencies (except homes for aged, as above). The turnover rate for hospital maintenance employees (112 percent) far exceeds the turnover rate in the other types of agencies and is so high as obviously to impair efficiency. Office workers in hospitals also show a much higher turnover rate than office workers in other agencies.

Professional workers in voluntary casework agencies are for the most part caseworkers. The turnover rate of 24 percent for this group compares favorably with rates in Cleveland[4] in 1944, 1945 and part of 1946, which ranged from 27 percent to 30 percent. However, when the highly skilled nature of casework is considered, it is clear that replacement of almost one fourth of the casework staff in one year must be costly and hampering to the effectiveness of the work.

The relatively low turnover rate of 17 percent for full-time professional employees in voluntary recreation and group work agencies does not present the situation in the total professional staff. In this field the number of part-time employees exceed the number of full-time employees on January 1, 1948. As 43 percent of the agencies in this field stated that there was more turnover in their part-time staffs than in full-time staffs, the rate of turnover for the whole professional staff would be considerably higher than 17 percent. The turnover rate among maintenance employees in this field (64 percent) is much higher than the rate for maintenance employees in any but the hospital field.

*Part-Time Employees.* Of the 150 agencies, 43 reported having part-time employees; 21 of these were in the recreation and group work field. Only in this field did the part-time staff constitute a considerable portion of the total staff. Therefore the problem of turnover in part-time staff is one which principally concerns the recreation agencies.

*Seasonal Trends.* In order to discover whether there were seasonal trends of employment in other than camps and similar short term activities of the agencies, the study called for turnover records by four month periods. Staff separations and additions were fewest from January to April, but the number of separations and additions in each of the four periods was about the same; indicating a fairly constant level of employment.

*Conclusion.* 1. Personnel turnover is recognized as a problem by one-fourth of the agencies studied; and it appears to be a problem of significant proportions, although not always recognized, in at least half the agencies.

2. The turnover rate in the agencies as a whole is higher than was to be expected, as it was higher than the national turnover rate in manufacturing. In hospitals, the turnover rate was extremely high as compared with other types of social and health agencies. Turnover in several fields and for all classes of employees was sufficiently high to call for efforts toward reduction.

3. In view of the high cost of turnover and its frequently undesirable effects on service, it is important to eliminate all turnover that is not unavoidable or desirable. One essential step in that direction is the establishment of sound personnel practices.

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(1) The basic study, of which this Annex is a brief summary, is filed with other Survey material with the Greater Boston Community Council (Research Bureau).

(2) Walters, J. E., Personnel Relations, New York, Ronald Press Co., 1945.

(3) Computed from 1947 monthly totals in Monthly Labor Review, Bureau of Labor Statistics, U. S. Department of Labor, April, 1948.

(4) Study of Turnover of Professional Social Work Personnel in Greater Cleveland — Welfare Federation of Cleveland, May, 1947.

# ANNEX III

## Salaries and Personnel Policies in 157 Public and Voluntary Social and Health Agencies in Greater Boston[1]

This Study presents certain data on the salaries and personnel policies operative in April, 1948, in 157 public and voluntary social and health agencies in Greater Boston.

Highlights of the information obtained are summarized in the following paragraphs. For details on the more important items, the full text and tables should be consulted.

*Salaries.* Salary figures were sought for personnel on professional jobs[2] only. Those tabulated (See Appendix B— full report) are for 943 full-time workers on 17 kinds of jobs.

Variations in pay make it somewhat difficult to determine prevailing rates. On the six most common jobs (50 or more persons reported), the following gives some indication of general practice:

83 percent of caseworkers received $2000-2999 per year

82 percent of casework supervisors received $2500-3999 per year

77 percent of group workers received $1750-2999 per year

85 percent of program directors received $2500-4999 per year

78 percent of nurses received $2000-2500 per year

77 percent of executive directors received $2500-6999 per year

Certain interesting contrasts may be seen between these general tendencies and the extremes, particularly at the lower end of the scale. Almost 11 percent of caseworkers were paid under $2000, most of these *less than $1500 per year.* In view of the fact that the average rate for general stenographers in January, 1948, in Boston was about $1960 per year[3], it must be wondered what quality of professional service is being obtained at these figures. On three of the other five professional jobs mentioned, 7 percent of casework supervisors were paid under $2250; 30 percent of group workers, under $2000; and 6 percent of executive directors, under $2000.

Another feature of the salaries is the relatively wide range of rates on certain jobs. Possibly some of this may be regarded as natural and fitting. The job specifications divided some jobs, such as program directors, into three classes in recognition of the comparatively wide range of skill and responsibility required. However, when 78 percent of nurses, who were divided into two classes, are found within a salary range of only 25 percent, while 85 percent of program directors show a spread of 100 percent, certain serious questions are raised. Is there enough differential in the small-range group to reflect adequately the differences in skill and responsibility of various members of the group and to provide a reasonable incentive to improvement? For the wide-range group, can the differential be justified in terms of actual job content and performance? If so, can properly qualified persons be obtained at the lower figures?

*Education.* The educational levels represented by about 1100 persons on professional jobs, as reported by the agencies, seems to bear out some of the concerns which were felt in examining salaries. Qualifications for various jobs differ widely, despite the fact that agencies may classify them as the same on the basis of the duties which are supposed to be performed. Among caseworkers in the voluntary agencies, 17 percent had had no professional casework training, while one-third of those classed as professional workers by the public agencies had gone no further than high school graduation. Among private agency group workers, 60 percent had had no professional training.

It would be unsound to try to decide on the basis of these figures alone just how great a gap exists between the training needed on these jobs and the training which workers on the job have had. Detailed examination might show that a high degree of formal professional social work education is not necessary for some of the jobs. Also, in many instances there is probably an experience or on-the-job training factor which offsets to a greater or less extent a lack of classroom training. However, the wide range of education reported on some jobs suggests that there is more difference in job content among persons classified on the same jobs than some agencies recognize. It would seem desirable to clarify further the nature of these differences and the educational preparation needed for various jobs. This would be particularly useful in employing inexperienced personnel. A significant indication of what can be done when job content and qualifications are more standardized can be seen among the voluntary health agencies, where 93 percent of the professional workers have had what appears to be relatively similar professional preparation.

*Working Hours.* Information on working hours was compiled for five occupational groups designated as executives, supervisors, professional workers, clerical workers and maintenance workers.

The agencies were about evenly divided between those in which the work week for executives, supervisors and professional workers was 40 hours or less, and those where it was more than 40 hours. For clerical workers, the work week of 40 hours or less predominated. Maintenance workers in most of the agencies worked over 40 hours per week.

A work week of 49 hours or more plus overtime was more frequently reported by recreation and group work agencies than by the other types of agencies. In the voluntary casework and voluntary health agencies, the 36 to 40 hour week prevailed. In voluntary hospitals, a 41 to 48 hour work week was most usual for all classes of employees. A work week of 35 hours or less was reported by a substantial proportion of the public agencies. Most of the remainder of this group reported a 36 to 40 hour week.

*Paid Leaves.* The prevailing policies with respect to vacation with pay were as follows: 67 percent of the agencies gave professional workers 4 or more weeks of vacation per

(1) The basic study, of which this Annex is a brief summary, is filed with other Survey material with the Greater Boston Community Council (Research Bureau).

(2) To classify personnel, voluntary agencies were asked to use job specifications in the "Personnel Policies Study of Private Social Work Agencies in the Greater Boston Area, 1946-47" published by the Greater Boson Community Council; public agencies were asked to use civil service classifications.

(3) United States Department of Labor, Bureau of Labor Statistics, OFFICE WORKERS, SALARIES, HOURS OF WORK, SUPPLEMENTARY BENEFITS, Boston, Mass., January, 1948.

year; clerical workers received 2 weeks in 48 percent of the agencies and 3 weeks in 27 percent; maintenance workers received 2 weeks in 72 percent of the agencies.

Paid leaves during illness were granted by all but 3 of the 157 agencies. The majority of public agencies allowed 3 weeks for this purpose for all types of employees. The voluntary casework agencies were the highest on this item, with 64 percent granting 4 weeks or more to professional and clerical workers.

Paid leave for educational purposes was reported on by 139 agencies. The 89 agencies which give such leave included about three-fourths of the voluntary casework agencies, hospitals and health agencies; and about one-half of the public agencies and voluntary recreation and group work agencies. During educational leave, 61 percent of the agencies which grant such leave pay partial or entire salary; 44 percent require the worker to return to the agency for a stated period after completing his education.

*Pensions.* A total of 154 agencies answered the question as to whether a pension or retirement plan is provided for employees. Eighty-three have such a plan for professional employees; 80, for clerical employees; and 51, for maintenance employees.

*Formal Statements of Personnel Policies; Formal Problem Procedure.* A printed or written statement of personnel policies was reported to be issued in 110 agencies. Copies of such statements were submitted by 35 agencies. Some showed wide coverage of possible topics but others needed strengthening by inclusion of additional standard items. Four omitted even to mention vacations; 5 said nothing about leave for sickness; and 8 had no statement regarding hours of work.

An established Problem Procedure (sometimes called Grievance Procedure) was reported by 57 agencies.

## SUMMARY

The above provides a brief, generalized picture of salary levels in these 157 public and voluntary social and health agencies, and of policies on several major items of personnel administration.

Formulation of a complete and specific body of recommendations to cover the needs in regard to agency personnel administration demands detailed consideration of the matters involved, and participation in this task by persons thoroughly familiar with each of the various fields of service. Neither of these requirements can be met at the moment by this Study. It therefore is believed that action resulting from these findings should be as follows:

*Recommendation 1:* Agencies should give careful attention to defining clearly the content and responsibilities of various jobs and to establishing qualifications and salaries commensurate with these aspects of the jobs. Efforts should be made or continued to formulate a reasonably complete and equitable framework of policies covering other items of personnel administration. The period when any other changes are made as a result of the recommendations in the Divisional Survey Reports should be recognized as particularly opportune for carrying out this recommendation.

*Recommendation 2:* Wherever the items in Recommendation 1 are of interest to all agencies or groups of agencies or affect their interests, the Greater Boston Community Council, through its Personnel Practices Committee, should provide suggestions for agency policy and action and coordination of and assistance to agency efforts. This Committee should work closely to this end with the appropriate Divisions and Sections of the Council.

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